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THE EIGHTEENTH CHARLES VALUE CHAPIN ORATION
CHAPIN AND MODERN EPIDEMIOLOGY*

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IT IS CUSTOMARY on occasions of this kind for the speaker to express his appreciation of the honor involved. I hope that my reference to this will not sound perfunctory, for I am very much aware of this honor which is more than a personal one. It is an honor both to me and to the university I represent.

My knowledge of the man, whom we honor tonight, comes from a study of his portrait and his writings. The former gives us the picture of an earnest, almost wistful man with academic idealism, written on his face; his writings, which span a period of fifty years, give us a record of his thoughtful opinions which carry with them the convictions of a man—confident that what he was doing was right. Regardless as to what his contemporaries might have said a generation ago about Doctor Chapin's dull columns of figures, bio-statisticians have certainly leaned heavily on them ever since and two generations of students of epidemiology have been brought up on them. I have enrolled myself among these students. It is for this kind of education that I also wish to express my appreciation this evening.

In an appraisal of Doctor Chapin's life and work, particularly as an epidemiologist, I have drawn upon the opinion of my senior colleague, the late Professor Charles-Edward A. Winslow;[1] as well as the late Doctor Haven Emerson. The latter stated in the foreword of a book which contains some of Doctor Chapin's collected papers, that "the truest recognition which we can give to his leadership is to search for the answers of the questions he has phrased."[2] This will be the text of my talk this evening.

First, in order to consider questions, that Doctor Chapin "has phrased," we must project ourselves back into the environment of that half century in which he worked,—from 1880 until 1930. This was the period marking the beginnings of the sanitary age. The militant reformers who promoted preventive medicine and hygiene at this time were in every sense of the word true crusaders, dedicated to the cause of pure water, clean food and milk for America: W. T. Sedgwick of Boston, Hermann Biggs and Haven Emerson of New York, Doctor C.-E. A. Winslow of New Haven and no doubt, many others. These pioneers of public health strove through health education and other various ways to stamp out infectious diseases by improving environmental sanitation, by applying the new science of bacteriology. The medical profession at that time was dragging its feet as far as pushing this cause. Politicians also took a dim view of these reforms and it was a situation which badly needed champions, if there was to be any change. Like the British leaders in London,—Chadwick and Simon before them, Sedgwick and his followers fought against odds, for improvements in the slums, and for social welfare in an age which regarded such efforts as local benevolences rather than the normal and proper responsibilities of both laymen and physicians. Before this period of social awakening, George Bernard Shaw's epigram that, "The trouble with the poor—is poverty" would have seemed to be a good enough description for the whole grimy business.

That it would have required statisticians to tip the balance in favor of such reforms may seem strange, but here was an instance where facts turned out to be more convincing than words. The facts were, that the prevalence of disease and the death rates were higher, often far higher in the slums than in other parts of the city. To prove this, year after year such statistics were shown to those in control of municipal conditions until the city officials simply had to do something about it. Chapin, no doubt, was one who provided these facts from his carefully compiled lists of vital statistics about disease in this city of Providence, and few

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people had a better appreciation of the impact of good and bad environments on the health of the community than did he. He must have known this city as a country pastor knows his flock.

And now I wish to come quickly to the point of my remarks which concern Doctor Chapin's role, not as a sanitarian which he had to be most of his life, but as a *modern* epidemiologist, a man well ahead of his time. Many of his papers fail to reflect this fact. Instead they illustrate the contemporary concept of an epidemiologist which in those days called for a man whose first duty was to stamp out infectious disease much as a preacher might try to stamp out sin. Today the epidemiologist has at least two functions: first to study the circumstances under which disease occurs; and second perhaps to do something about the situation, or at least to get someone else to do this for him. One can contrast these functions with those of a fireman and his academic counterpart. Although the fireman's duty may be to put out fires, his academic counterpart is one who studies conditions within a house or a city which will lead to a better understanding as to how fires develop and how they get out of control. Although Chapin was a good "fireman" and served as the Superintendent of Health of the City of Providence for the incredibly long period of 48 years, he also found time to devote to the second and more academic function, namely, to visualize what his figures meant. As an example, one of his last papers is titled, *Science of Epidemic Diseases.*[3] Some may question whether epidemiology has even yet achieved the stature of a *science,*—contrasting it with meteorology and pointing out that both subjects deal with fairly nebulous things. But it has the hope of a science today and its methods are fairly accurate which Chapin had begun to use as early as 1913, and again in 1926, when we find him writing on the *variation* of types of infectious diseases. He was among the first to note that scarlet fever used to be a severe and common disease and during his lifetime he saw it becoming less severe and less common. Why was that? This was long before the days of antibiotics. In other words, almost fifty years ago, he was pondering on questions as to what makes each generation have its own diseases, as well as its own methods of handling them. Thus he says, in his Sedgwick Memorial Lecture,—"it is hoped that someone will give further study to the problem, for its solution seems to me to be a matter of great moment."[4]

I too wish to speak of this point, namely the *variation* in disease, because it is with the changing pattern of diseases that modern epidemiology is now concerned. Today the subject has progressed and the concept of this "science" has broadened to include all kinds of disease (not infectious disease alone). Heart disease, cancer, drug addiction and benzol poisoning, all have their epidemiologies which are concerned with various sets of predisposing circumstances, and we all know that circumstances are wont to change. This epidemiologic concept, namely to measure and study these circumstances which predispose to disease, whether they be microbiological, immunological—even political or religious, has become an integral part of the principles and practice of medicine today.* It is a field no longer dominated by or limited to public health officials or public health professors for it is a growing subject now taught in medical schools. *Clinical epidemiology*[5] has now come into its own too, and we find it in medical textbook descriptions of a disease today. It is a field now in which doctors of all kinds have much to contribute and much to learn, as has been well exemplified in Dr. J. N. Morris' small book, *The Uses of Epidemiology.*[6] As an example of the physician's and surgeon's interest in this subject today we see Doctor Paul Dudley White being deeply concerned with the epidemiology of heart disease and its prevalence in different places.[7] We see the late Doctor Evarts Graham, a well-known surgeon, studying the epidemiology of cancer of the lung and we see Doctor Joslin studying the epidemiology of diabetes.

But granted that epidemiology is a growing subject today, let us return to the changing picture of disease. In the United States the diseases of the twentieth century have shifted almost with each decade, just as the ways of life have shifted during the last half century. In Figure 1, we see the experience of fifty years in the U.S.A., indicating that the infectious diseases which were largely responsible for killing people in 1900 have now been replaced by quite another set. The change, whether for the better or worse, has by no means come about entirely through the efforts of the medical and public health profession, although they have had a major part in it, but others have had a hand in it too. Building contractors have not been slow to recognize that comfort and longevity are desirable commodities. Plumbers and manufacturers of iceboxes have contributed their share. Their combined efforts, when added up, have brought about a reduction in the hazards of early life, most of which were due to acute or chronic infectious disease. To a certain extent modern North American living now calls for surroundings, habits and tranquilizing drugs which would have seemed strange, artificial and perhaps luxurious to our great-grandparents. Sanitation, refrigeration of food, central heating, the automobile, antibiotics are all factors of epidemiologic significance which have exerted an impact on the

*Various other names have been proposed for this kind of approach: *social pathology, population pathology, social medicine,* but the descriptive term *epidemiology* seems the most apt.

illnesses we acquire and the members of the population who are here to acquire them. We should expect then, as the hazards to early life and threats to premature death are curtailed, the ever increasing number of people arriving at age 65 will create more and more opportunities for them to acquire the *diseases of old age*, and more opportunities, if you will, for the geriatrist. From an epidemiologic point of view this is an example of man's reactions to a changing environment and new ways of life. It makes us realize that if man is successful in conquering certain diseases, particularly of early life, this in itself is not the end of the struggle—not at all. For in the face of a decline in infectious disease as measured by death rates a host of new problems is appearing and new challenges to face. One can hardly look at this shifting scene without wondering whether it is good or bad—what it will add up to—tomorrow. It seems to represent man's struggle to survive according to his own interpretations as to what is good for mankind—and for himself. Doctor Rene Dubos of the Rockefeller Institute perhaps thinks that we don't recognize the importance of the element of struggle in this picture—he has gone so far as to say in his recent book[8] "complete freedom from disease is almost incompatible with the process of living."

At least the situation should encourage efforts to develop preventive measures designed to deal with the diseases of middle life or old age, although so far the record is not so good here. In fact the death rate among adults is not declining in a spectacular fashion (Figure 2), female mortality has kept a downward course, but the decline in male mortality is much less. As a reflection of this it has been claimed that the average married woman in this country may expect to look forward to ten years of widowhood. This results from the fact that there are certain common diseases which attack men in middle age which, in this country, are *not* declining. They include:—duodenal ulcer,—carcinoma of the lung, and coronary occlusion. The first of these is responsible mainly for ill health, the next two are killers, and not only are they not going down but they are on the increase.

The problem here is, that not only are these diseases not being conquered or controlled, at least as far as the male sex is concerned, but, as we watch them on the increase, one is faced with the fact that they seem to be so closely tied with modern living, that they are almost actual *products* of our age. Perhaps we even deserve the blame for having created them. You all know the story of attempts to incriminate rich diets and lack of continued physical activity, especially for the business executive, as contributing factors, although by no means proven ones, for the creation of vascular disease. Doctor Morris' studies on the incidence of angina pectoris and coronary disease in London bus drivers who sit, as opposed to bus conductors who scramble up and down an iron staircase, is a provocative example of clinical epidemiologic research here. The researches on excessive cigarette smoking as a factor in the genesis of carcinoma of the lung is another example. These then may be examples of diseases of our own making, and it is the prime duty of the clinical epidemiologist today to observe and weigh the evidence and consider the extent to which ways of living, which today we regard as acceptable, may not be all right; and, indeed may be as far off the beam as were living conditions in the seventeenth century in London where cholera and plague flourished. The Londoner's problems of that day were dirt, contaminated water supply, rats, lice and so forth, but apparently they were not aware that anything was wrong. Our problems—and our circumstances may be those of too much indulgence of creature comforts. We probably smoke too much, the students of alcoholism insist that we drink too much, and I suspect they are correct, although it is doubtful whether this is unique to this particular age. We certainly eat too

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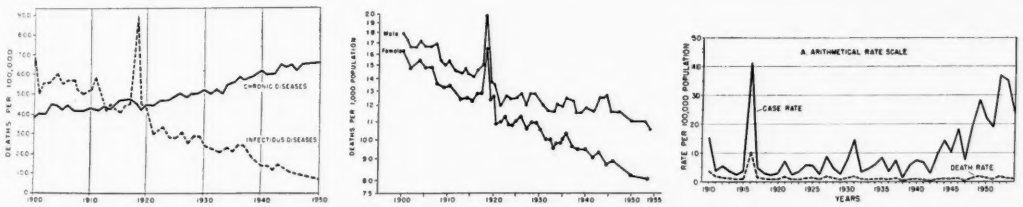

FIGURES 1, 2, AND 3

Figure 1. Deaths per 100,000 population from chronic diseases and from acute infectious diseases in the United States, 1900 to 1950. From Paul, J. R.: Clinical Epidemiology. Univ. Chicago Press, 1958. (Basic data from The National Office of Vital Statistics.)

Figure 2. Sex-specific mortality rates, United States, 1900-1954. The male rates are declining more slowly than the female. From Paul, J. R.: Clinical Epidemiology. Univ. Chicago Press, 1958. (Basic data from The Health Information Foundation.)

Figure 3. A 44-year-old poliomyelitis case and death rate record from the United States covering the period 1910-1954. From Paul, J. R.: Clinical Epidemiology. Univ. Chicago Press, 1958. (Basic data from the Communicable Disease Center, U.S. Public Health Service.)

much. Obesity has become a national disease in the United States. We are becoming more dependent on labor-saving devices than ever. This is a contagious tendency and we are prone to seek a life in which one pushes buttons in order to avoid physical exertion. On all these habits and ways of twentieth century life, the diseases of the second half of the twentieth century will depend, and so entrenched are these habits that it would sound out-of-order to say much against them. And yet, when I think of Doctor Chapin and his courage in facing up to the problems of his day,—one wonders whether we can pay tribute to this man without in some way following his example. It is unlikely that he would be indifferent to the present scene and it is probable that he would be measuring factors which he deemed were responsible for modern diseases.

However, the present scene is not all our fault. This pattern also depends on the effect which one disease has upon another. It sounds complicated, but biostatisticians tell us that no disease can be eliminated or reduced in rate without its having an effect on the rates of all the other diseases to which man is heir. Thus, as the acute infectious diseases, which often attack young people, are brought under control, debilitating and degenerative diseases begin to take over a little later in life. Another effect is that of postponing the time at which a given disease is acquired. An illustration of this trend can be found in a familiar disease,—poliomyelitis. It is now recognized that during the past half century or more the epidemiologic behavior of poliomyelitis has been undergoing an evolution. Under primitive sanitary conditions poliomyelitis did not amount to much. For example, prior to 1900 this disease was uncommon and regarded pretty much as a curiosity. It had a different name,—"infantile paralysis," for it was a disease then largely restricted to infancy. How different that is from the present generation when "polio" came to be regarded as a dreaded scourge which before the days of the Salk vaccine was ever on the increase in this country and ever more prone to attack older children and even adults. This ominous trend occurred in many countries, notably Scandinavia, Western Europe, North America and Australia. What the story has been in the U.S.A. is illustrated in Figure 3. However, evolutional experiences of this kind have not been universal, for in many parts of the world, notably in North and South Africa, Egypt and the Middle East, and in certain countries in Latin America, the transition from sporadic "infantile paralysis" to epidemic poliomyelits has apparently not yet begun. All of these latter countries could be called primitive as regards sanitary arrangements by our standards. In other words, mild, endemic poliomyelitis still persists in those areas with substandard sanitation. Severe, epidemic poliomyelitis has come to the most advanced countries and has remained there.

In seeking an explanation for this apparent paradox, the opinion has been expressed that the epidemic behavior of "modern polio" is associated with those public health measures or those circumstances which are effective in raising the level of environmental sanitation, within a given area. This would have been a most disturbing opinion in the days of Sedgwick and Biggs. In an attempt to find out more about this, Payne of the World Health Organization has recently drawn attention to the inverse relationship between *infant mortality* rates collected from a wide variety of nations throughout the world, and the *recorded incidence* of poliomyelitis. Infant mortality rates are generally considered as an index of certain types of environmental sanitation, and, in other words, as sanitation improves, infantile mortality rates nearly always go down, and somewhat surprisingly poliomyelitis rates nearly always go up during the same general period of years. This is shown in Figure 4. It does not mean that the decrease in the infant mortality rate

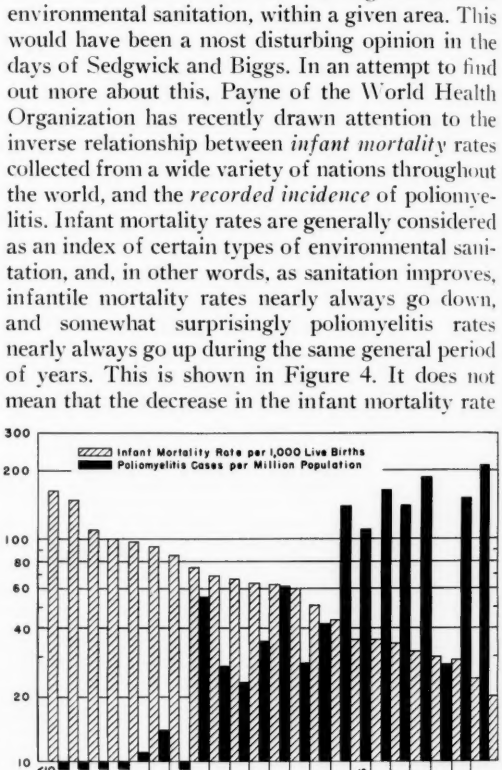

Figure 4. High infant mortality rates have been associated with low poliomyelitis rates in some countries, and vice versa. From Paul, J. R.: Clinical Epidemiology. Univ. Chicago Press, 1958. (Basic data from Payne, A.M.-M.: Papers and Discussions presented at third International Poliomyelitis Conf., 1954. Philadelphia, J. B. Lippincott Co., 1955.)

is directly responsible for an increase in poliomyelitis, but one can easily imagine reasons why these rates can both be affected inversely by the same process. For, the suppression of opportunities for the infant to acquire enteric infantile disease of a variety of different kinds, can at the same time, suppress opportunities for the acquisition of poliovirus infections, which, *if acquired during infancy*, are apt to be very mild affairs. More than 99% of such infantile poliovirus infections are negligible as far as causing symptoms. They are inapparent

infections, from which the infant gains some immunity. This is the most salutary form of natural immunity and as you may know it is the present basis for proposing a live virus vaccine for poliomyelitis to supplant or supplement the Salk vaccine. If, on the other hand, the infant is so protected during the early years of life that he fails to acquire these inapparent infections from local strains of poliovirus, he may subsequently reach school age having failed to gain any immunity to this infection. At this age, *i.e.*, by the time the same child enters school or later, a poliovirus infection is apt to be more severe and by college age still more severe. Less than 99% of infections are subclinical and that segment of the population which is non-immune grows larger each year until an epidemic comes. As such, *postponement* of poliovirus infections by sanitary methods along with a failure to vaccinate, tends to bring poliomyelitis out into the open as it were, and to bring on epidemics with reported attack rates for paralytic poliomyelitis which are higher than were those recorded in the days of "infantile paralysis." It is small wonder that one looks back to the days before the Salk vaccine as to a somewhat sinister situation. It seemed to go directly opposite to the tenet that one could achieve perfect health through cleanliness. One might even suggest that sanitation had backfired as far as this disease was concerned.

One could quote other examples of disease which are characteristic products of our present way of life. The new penicillin resistant staphylococci which have found their way into an apparent vacuum created by the use of antibiotics, is another example, and the sizable number of cases of serum hepatitis which have resulted from the increasing uses of transfusions and parenteral medications is another case in point. I hesitate to mention further examples because each one raises such a long list of new questions which offer a great challenge to modern epidemiology.

Apparently there are all too few people like Doctor Chapin, who began almost fifty years ago to consider this question of variation in disease, and what does it mean. Let us hope there will be others like him,—men who will recognize what is going on around us and who will measure carefully before advising their therapy,—or proposing reforms, so that the facts can speak. These men will not be the kind who plan to cleanse the world of disease. They will seek to find some means of grappling with the problem of illness in a world where living things, be they viruses or men, are both struggling to survive. These men will also recognize that "the road leads up hill all the way,"—but at least it leads up.

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(Providence Journal Photo)

Doctor John R. Paul (right), Professor of Preventive Medicine at Yale University Medical School, is congratulated by Doctor Francis B. Sargent, President of the Rhode Island Medical Society, for being selected as the eighteenth Charles V. Chapin orator.

OUR ALLIES — THE HOSPITALS AND BLUE PLANS: ASSETS OR LIABILITIES?*

FRANCIS B. SARGENT, M.D.

The Author. *Francis B. Sargent, M.D., President of the Rhode Island Medical Society, 1958-59.*

AT THIS MEETING it is customary for the retiring president to give an account of any special and important business transacted by the Society in behalf of the members during his year in office. He also is expected to speak on some subject of vital importance to the Society and concerning which he has made a special study.

After many meetings, and intensive study by a special committee, a Physicians Service contract for subscribers in the medium income group has been formulated. It has been accepted by the House of Delegates of the Society and Physicians Service, and we expect the insurance to be available to the public in the immediate future.

The Committee on Group Professional Liability Insurance has negotiated through Starkweather and Shepley a contract with the St. Paul Fire & Marine, replacing our arrangement with the Lumbermen's Mutual, which became progressively more unsatisfactory with each passing year. The crisis came, when having sustained practically no loss and having collected tens of thousands of dollars in premiums, the company went to the insurance commissioner requesting a substantial increase in rates. This action was done without our knowledge and when rejected, the company served notice of withdrawal from the writing of malpractice as of May 1, 1959. Our professional liability insurance committee deserves our thanks for finding a satisfactory replacement. It would be a shame if we had to downgrade our present high quality of medical care because of the specter of litigation. By providing adequate and certain coverage, your Society hopes to prevent this situation from happening here.

Recently, the president was authorized by the Council to appoint a potentially very important committee to act with our allies, the hospitals and Blue Cross, in two important areas. The first is our mutual defense against outside attack; the second, to resolve conflicts of interest among us as they arise.

This action brings us directly to an evaluation of our allies—the Blue plans and voluntary hospitals —in our struggle for survival.

If any of you entertained any doubt about the wisdom of the Society's opposition to Medicare, it certainly should have been dispelled by the appearance of the Forand Bill. Sponsored by the big labor bosses and federal bureaucrats, this legislation is meant to embarrass our profession and its allies. It cleverly puts us in the position of resisting better medical care for the weak and helpless. The technique, though shopworn, is still used to advantage to harass us. The bill, if passed, will be a great step toward federal operation of Blue Cross and the eventual control of voluntary hospitals. The social planners hope we will choose a lesser evil—the control of hospitals and clinics by labor.

In evaluating the strength and weaknesses of our allies from the doctors' point of view, consider first the Blue Shield, or in this state, Physicians Service. This is our organization. It is under our control through our House of Delegates which elects the governing board by a majority vote from candidates freely nominated from the floor. There is not even the restriction of a nominating committee. Every member of the House is free to express his opinion in a forthright manner.

In a social system where saving for a rainy day is out of fashion, where the public relies on time payment and prepayment plans to take care of expenditures, the injection of a third party into doctor-patient relations becomes a necessity. Of course it increases the over-all cost to the public. So does any insurance plan. To meet this need our Physicians Service is just about ideal. It is 100% an asset and in no way a liability. This is not equally true of the operations of our other major allies in the health field, the hospitals and Blue Cross, both of whom are prime targets for our most vocal critics —the big labor bosses.

Great advances in the quality and availability of medical services have been made possible by the expansion of our hospital facilities. We are indebted to the unselfish efforts of the dedicated members of our hospital boards of trustees and their equally dedicated directors. They have made it easy for us to give our patients a high quality of hospital care. However, the able administrator of a hospital

*Presidential Address delivered at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.

poses certain problems for us. A director is obviously desirous of running a very efficient organization. He will endeavor to make every member of that organization believe that the hospital is the most important thing in that individual's life. No doubt on that matter will ever be allowed to cross the subject's mind. In his zeal to improve care and efficiency in the hospital he may produce groups of doctors who will be a flock of sitting ducks for the power hungry.

From our point of view we want doctors to have more influence, not less, in hospitals. We feel that practicing physicians should support their hospitals, not be supported by them. We can accomplish this by more voluntary contributions on the part of the staff toward the operating deficit of hospitals. Such action will foster in us a sense of responsibility and concern in the operation of the hospitals. It is still true that he who "pays the fiddler calls the tune." Our safety demands that we do not allow hospitals to compete with private practitioners in the care of patients. The men of good will who operate our hospitals may see only immediate public benefit in hospital sponsored clinics, and not the ultimate damage done to our free enterprise system, only under which the best medical care is possible.

Labor will certainly continue to push for its own clinics and hospitals as it launches an attack on the high cost of medical care. Except in special situations such as the care of the aged or indigent, the leaders of labor are no more sold on government medicine than we are. Labor wants more efficient and less expensive medical care. Using state medicine as a bogey man they are gradualy setting up clinics and hospitals for the members of their organization and the families of members, under a closed panel system, of course.

This clash between labor and medicine is a tragic one. No one rejoiced more at labor's gains in the thirties than did the doctors, who saw in a better distribution of the profits of industry a realization of simple social justice. The labor bosses are now beginning to realize as well as we do that continuing raids on the profits of industry and the savings of the thrifty will eventually kill the geese that have been laying labor's golden eggs. For this reason, they are looking around for services for the worker at lower cost and here is where we enter the picture. They would put us in the same position as the farmer who pays a very high price for his freedom by working long hours at low returns. The opportunity to put pressure on us comes at a time when, in the words of a great prelate, "the public mind has been psychologically unsettled by the welfare state."

Here are the high points in labor's atacks:

1. Blue Cross, and most Blue Shield plans, require hospitalization for the realization of benefits. The plans result in longer hospital stays and over-utilization of services.
2. The rise in the cost of hospital care has been the largest price rise of all, rates being up 256% since the war.
3. The race of insurance coverage plans to keep up with what the surgeon charges is futile.
4. Unlimited free choice of physician is a failure. People choose quacks for doctors.

In answer to No. 4, perhaps it would be proper for the labor boss to choose a man's food, his clothing, his housing and even his wife. If the worker selects his own, he might make a mistake.

In essence, criticisms 1, 2 and 3 attempt to combine the technique of one-tenth truth and nine-tenths half-truths. Labor is attempting to set itself up as champion of the people against the high cost of sickness. However, its concern over the high cost of hospital care does not extend to certain other areas: e.g., if a worker buys a $3,000 car on time payments, he usually ends up paying an extra $1000 for interest and other charges. This extra charge would take care of the cost of Blue Shield and Blue Cross for eight years even in the highest income plans. These plans cost only two-thirds as much as a family, which uses two packages of cigarettes daily, spends for tobacco. The recent attempt of certain labor leaders to organize the nonprofessional employees of hospitals raises the question—are they interested in lowering hospital costs or are they interested in the control of everybody and everything?

The rising cost of medical care has not been due to higher fees for physicians. Actually, surgical fees have advanced only fifty per cent as fast as the wages of labor; house calls and office visits have advanced only fifty-nine per cent as fast.

There is no doubt in anyone's mind that the cost of hospital care has risen steeply. But seventy-one per cent of the hospital's expense is for wages for employees. Thus labor's gains have been responsible in no small measure for the steep rise in hospital bills.

Although concentration of such services as X-ray and laboratory work in the patient's hospital day has helped shorten his stay there, these same services have contributed to the rise in costs, costs which cannot be reduced except by reducing in some measure the high quality of service.

There may well be some grounds for the criticism that Blue Cross and similar plans encourage over-hospitalization and over-utilization of hospital services. It is only natural that the public, having paid the insurance premium, is anxious to collect on what it considers its investment. One study in the midwest reaches the conclusion that overuse of hospitals accounts for as much as twenty per cent of the total patient days!

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IATROGENIC DISEASE*

ANTHONY CAPUTI, M.D. AND JANIS GAILITIS, M.D.

The Authors. *Anthony Caputi, M.D., Cardiologist and Senior Physician, Newport Hospital, Newport, Rhode Island. Janis Gailitis, M.D., Associate Physician, Newport Hospital, Newport, Rhode Island.*

IATROGENIC DISEASE has been a major problem of medical practice since the earliest days of medicine. The past twenty-five years, but particularly the past decade, have been a revolutionary period in the drug therapy of disease! Drugs have been released in large volume since the advent of the age of chemotherapeusis and tranquilization; the benefits have been many but the danger of drug intoxication has increased. The problems of therapy have been affected by the advertising of all types of drugs through many channels including journal advertising, drug literature and salesmen.

In a very comprehensive article Barr[3] discussed the hazards of modern diagnosis and therapy. Drug intoxication, due to digitalis and bishydroxycoumarin (dicumarol), modification of the internal environment by potent diuretic therapy, allergic reactions of various types, and the dangers of mechanical procedures, including accidents, were among the many topics analyzed. There were major toxic reactions in 1,000 cases studied, an iatrogenic incidence of 5%. An article by Lepper[4] reveals the wide scope of the subject and the inadequacy of case record summaries in discovering all cases.

The purpose of this report is to evaluate the incidence of iatrogenic disease in medical hospital admissions.

Material and Methods

This study extends over a one-year period, from January 1, 1958 to December 31, 1958, and includes 1,604 cases. All medical admissions were evaluated by data analysis of charts. It is clear that certain facets of iatrogenic disease escaped discovery in spite of excellent chart material. For instance, some febrile episodes were not explained in the progress notes. The nurses' notes proved valuable in the accurate determination of iatrogenic problems. Psychiatric iatrogenic problems could not be evaluated, and this fertile and important field was eliminated by the nature of the study. Errors of commission and omission involving diagnosis and treatment would not yield to accurate evaluation.

The analysis of 1,604 cases resulted in a breakdown of data into five categories (Table I): I) Drug Intoxication; II) Mechanical Factors and Procedures; III) Hospital Infections; IV) Transfusion Reactions; V) Modification of Internal Environment. Each of these categories is illustrated by a case presentation when indicated.

I. Drug Intoxication

Extension of pharmacologic effect is the major problem in medical practice. As anticipated, digitalis, dicumarol and other anticoagulants, and insulin played the major roles. Dicumarol particularly exemplifies the extremes of pharmacologic effect, i.e., a tendency to bleeding and prothrombin escape. Other problems included vitamin deficiency syndromes, cortisone induced gastrointestinal bleeding, bone marrow depression, superinfection secondary to cortisone therapy, gastric retention and syncope. Anaphylaxis and allergy applied particularly to penicillin and included four cases in 1,604 admissions, an incidence of 0.25%. Welch, et al[4] conducted a nationwide survey on severe reactions to antibiotics. Of 1,070 severe reactions, 809 were of the anaphylactoid type, and 793 resulted from penicillin. One of our cases was of the severe anaphylactoid type with recovery. The cases in this group totaled 64. Following are case summaries illustrative of this group:

M.W.—a fifty-seven-year-old colored female developed shock, wheezing respirations and laryngeal stridor immediately following an injection of 600,000 units of procaine penicillin for

TABLE I
1,604 Medical Cases
January 1, 1958 through December 31, 1958
Incidence of Iatrogenic Disease

Category	*Cases*
Drug Intoxication	64
Mechanical Factors and Procedures	30
Hospital Infections	7
Transfusion Reactions	10
Modification of Internal Environment	3
Total Cases	114
Incidence	7.1%

*Presented at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.

treatment of a mild acute upper respiratory infection. She recovered from this near-fatal penicillin induced anaphylactic reaction following heroic therapy with epinephrine, vasopressor agents, oxygen, corticosteroids, penicillinase and antihistamines. Subsequent electrocardiograms revealed an anterior wall myocardial injury pattern that required prolonged hospitalization for eventual recovery.

B.M.—an eighty-six-year-old white male was treated in the hospital with soluble heparin averaging 200 mg. daily, in divided doses, for the treatment of an acute myocardial infarction. At the time of a massive gastrointestinal hemorrhage which proved fatal, the Lee-White coagulation time was 40 minutes. Therapy included fresh blood transfusions and protamine.

II. Mechanical Factors and Procedures

This category includes injuries, falls, pressure dermatitis and decubitus ulcers, fecal impactions, and a case of pulmonary fibrosis postradiation therapy. A very important mechanical problem is that of catheterization—mechanical cystitis is an invariable accompaniment of the indwelling catheter with ascending cystopyelitis as the sequel. There are thirty cases in this group and the following case is illustrative.

D.G. — a forty-one-year-old white female, without genito-urinary symptoms, was catheterized because of a complaint of low back pain. Urinalysis was negative. Shortly thereafter she was hospitalized with acute pyelonephritis as revealed by a urine culture containing over 100,000 colonies of E. Coli per 1 ml. After sensitivity studies, therapy was commenced with the appropriate drug and eventual recovery after two weeks of hospitalization.

III. Hospital Infections

Recognized hospital infections included seven cases. Catheterization of the urinary bladder seemed to be the major cause in this group. Secondary pneumonias including micrococcus pyogenes as the etiologic group included the remaining cases. The problem of hospital infections is well reviewed by Taylor[5] and measures for control are outlined. The following case illustrates one aspect of the problem.

L.S.—an eighty-six-year-old white female was hospitalized for the management of left ventricular failure secondary to arteriosclerotic heart disease. A bronchopneumonia due to coagulase positive micrococcus pyogenes developed. This strain was resistant to all tested chemotherapeutic agents and the patient subsequently expired from the hospital acquired infection.

IV. Transfusion Reactions

There are many types of transfusion reactions, but the ten cases observed in this survey were generally of the delayed pyrogenic type. Harrison[6] indicates the incidence of pyrogenic reactions at 2.9%, and that of other reactions at 5%. It is believed that small thrombi, rubber tubing contaminants and small numbers of bacteria may produce pyrogenic reactions. No reaction was serious. Therefore, an illustrative case is not presented.

V. Modification of the Internal Environment

Homeostasis[7] is based on the interplay of many factors which to list a few include: fluid transport through vessels; kidney and hormonal regulation; fluid movements and concentration changes. Of course, the external environment is intimately related to host defense and the preservation of the organism. Alteration of homeostasis included only three cases in this series. Following is an illustrative case.

C.T.—a fifty-five-year-old white male with obstructive emphysema, bronchopneumonia and severe respiratory failure developed mental confusion, lethargy and irregular shallow respirations due to carbon dioxide narcosis while in an oxygen tent. Removal from this environment reversed the process in two hours with eventual recovery.

CONCLUSIONS AND SUMMARY

The physician has received much unwarranted criticism from the lay and professional press concerning iatrogenic disease. The term "iatrotechnical" is actually more descriptive and accurate. When disorders have been instigated by suggestion, examination or discussion by the physician they are termed iatrogenic. Conditions that are induced by technical procedures employed by physicians in medications, operations, procedures or examinations are termed iatrotechnical. Wakefield[8] has summarized these problems in excellent perspective. It is interesting to note the high incidence of iatrotechnical disease in this study of 1,604 cases—114 cases—or 7.1% of the total. While there were numerous problems involved, actual prevention of iatrotechnical disorders would have been difficult. The inherent risks in therapy are well recognized. Anticoagulant, digitalis, insulin and blood transfusion reactions are frequently observed. Catheterization of the urinary bladder should be restricted to absolute indications. The prevention of injury from falling out of bed has been reduced by the newer type of Hi-Lo bed. May[9] has pointed out that physicians are not the only ones involved in iatric problems. Parents are also responsible for difficulties such as toxicity of vitamin therapy in children.

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Prevention of iatrogenic disease will not be possible in all instances, but constant adherence to the following rules will minimize the problem:

1. Avoidance of routine orders;
2. Awareness of strict drug indications, pharmacology of the compound and possible side effects;
3. Delay in the use of new drugs until clinical trials have been extensive;
4. Restriction of the duration of therapy, with flexibility of regimen adjusted to the changing status of patient;
5. Appreciation of the natural history of disease, including remissions;
6. Avoidance of multiple drug therapy which in some cases totaled six to eight agents;
7. Appreciation of other modalities of therapy.

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OUR ALLIES – THE HOSPITALS AND BLUE PLANS: ASSETS OR LIABILITIES?

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It is readily apparent that a closer understanding between physicians, the hospitals and the Blue Cross is imperative if the problem is to be solved. If Blue Cross is unable to cope with the constantly rising cost of hospitalization, it faces the danger of being taken over by the federal government. If that threat becomes imminent, then a divorce of Blue Shield and Blue Cross becomes not only advisable, but imperative.

On balance, the value to us of the voluntary hospital and Blue Cross is great, the liability factor is negligible, if we remain consistently aware that each presents a calculated risk.

Keep Well and Out of the Hospital is the caption of one issue of labor's health and welfare magazine. This is the most constructive advice they have contributed. Certainly anything we as doctors can do to shorten a patient's hospitalization will relieve the present intolerable load on distracted nurses and hospital administrators. Within the limits of safety, we should do everything in our power to discourage unnecessary hospitalization, and also to effect short stays. If each of us can save Blue Cross three hospital days a week, and if this is done on a country-wide basis, the plan, and ultimately its subscribers, would save about 500 million dollars yearly.

As a profession we vigorously support the principle of private enterprise. Prudence demands that we oppose the welfare state in general and the regimentation of medicine by outside controls in particular. In general, because the welfare state and its eventual collapse will be nature's lethal remedy for overpopulation, and in particular, because it will rob us of a unique opportunity to serve the public. With the tremendous advances in medicine in the past four decades our ability to cope with human misery is without precedent. The public, now poorly informed and comparatively helpless in matters medical, deserves from us a generous return for its contributions to research.

Any differences with the American Hospital Association and the Blue Cross must be resolved. We will all hang together or separately. Our cause must be presented competently to the public by every means of communication. It must be made clear that only when an individual directly or indirectly pays his own way can he have free choice of physician and hospital.

The federal government has now become of paramount importance in any consideration of the future. If we are to have any place in the future we must follow the tactics of labor leaders and take an interest in political problems and candidates for office. As individuals we must enter politics to the extent of investing considerable time and money. We can never be a force in government without having a part in the selection of those who run it.

As a result of the activities of those who have mastered the technique of brain washing through mass propaganda and who destroy the integrity of the individual by taxing quietly and spending loudly, we find a preponderance of brutal force arrayed against us in our fight against regimentation. The intangibles, however, are on our side. Not the least of these is the fact that we have in our minds and hands the capacity to render dedicated service that money cannot pay for, that dictators and bureaucrats cannot give.

Interim Scientific Meeting

WEDNESDAY . . . SEPTEMBER 23

THE RHEUMATIC FEVER PROGRAM

As Administered Through the Division of Maternal and Child Health of the Rhode Island State Department of Health

THE Rhode Island State Department of Health, through the Division of Maternal and Child Health, administers the Rheumatic Fever Program.

At each rheumatic fever clinic, two types of service are offered:

1. *Diagnosis and treatment:* Children who are referred directly to the program by physicians and hospital clinics will be accepted for complete care, that is, any necessary medical, hospital or convalescent care during the time the child is under the care of the program. This service is available to families who are unable to provide private medical care.

2. *Consultation service:* Consultation service is offered to physicians for their private patients. This includes complete laboratory investigation, EKG, X ray and complete physical examination by a qualified cardiologist and pediatricians who are experienced in the investigation of rheumatic fever and rheumatic heart disease. The complete reports are sent to the referring physician.

3. *Congenital heart disease:* A limited amount of money is available for children who have congenital heart disease which is amenable to surgery. Recent advances in diagnostic studies and surgery have made this program a very important one. Even though the incidence of these anomalies is low, the cost often is beyond the means of the average family. The State Rheumatic Fever Program is offering its services to a limited number of children who have congenital heart disease which is amenable to surgery.

The evaluation will include diagnostic laboratory test, EKG, X ray and cardiac catheterization and cardioangio-cardiography to be done at one of the three hospitals in Rhode Island where this procedure is in operation.

Children who can be benefited by corrective surgery within approximately a year's period will be accepted on the program.

Children with congenital heart disease who, at the present time, cannot be benefited by corrective surgery will not be accepted for treatment under the Rheumatic Fever program. These children will be referred back after the above evaluation to the referral source with complete copy of the findings.

If, in the future, corrective surgery has been established for the congenital defect, the children may be referred back to the Rheumatic Fever program.

Who is eligible? All children under twenty-one years of age who are residents of Rhode Island and who have rheumatic fever, rheumatic heart disease or any condition leading to rheumatic fever or rheumatic heart disease or who have congenital heart disease which can be benefited by surgery may be referred by their private physician or hospital clinic physician.

Clinics are held at: Rhode Island Hospital, Charles V. Chapin Hospital, Memorial Hospital, weekly; St. Joseph's Hospital, biweekly; Woonsocket Hospital, Warwick District Nursing Association, West Warwick District Nursing Association, monthly.

What the clinics offer: Complete physical examination by a qualified physician; complete laboratory facilities; X-ray and fluoroscopic examination, if indicated; nutrition services; medical-social services; follow-up services; convalescent care, if needed; doctor's visits to home for those under the program; hospitalization, if indicated, and medication.

What does it cost? Service is available free of charge to all patients accepted on the program. Consultation and diagnostic services are also free.

How can you refer your patients? Call JAckson 1-7100, Extension 233, or write to the State Rheumatic Fever Program, Room 323, State Office Bldg., Providence. Appointments for clinic are made from the central office.

The rheumatic fever and congenital heart programs are financed 100% by state funds.

OFFICERS INSTALLED FOR 1959-1960

THE RHODE ISLAND MEDICAL SOCIETY

DOCTOR ALFRED L. POTTER, Providence obstetrician and gynecologist, was installed May 13 as the 100th president of the Rhode Island Medical Society, the nation's ninth oldest state medical association. He was unanimously elected by the Society's House of Delegates to succeed Doctor Francis B. Sargent.

Other officers elected and installed were Doctor Earl J. Mara, Pawtucket internist, as president-elect; Doctor Samuel Adelson of Newport, re-elected vice-president; Doctor Arthur E. Hardy of Warwick, secretary, and Doctor J. Murray Beardsley, treasurer.

The new leader of the state medical society is a native of Orange, Massachusetts. He received his high school training at Providence Classical, and he was graduated from Cornell University with a degree of bachelor of arts. In 1918 he received his doctor degree of medicine from Cornell Medical School. He served internships at Woman's Hospital and New York Lying-In Hospital prior to coming to Providence to establish his private practice. He also served for two years as a medical officer at the United States Naval Hospital in Brooklyn.

Chief of Staff at Providence Lying-In Hospital from 1946 to 1954, Doctor Potter has since been a member of the consulting staff. In addition, he is a member of the gynecological staff at Rhode Island Hospital and a consulting surgeon at both Pawtucket Memorial and Charles V. Chapin hospitals. He is a former clinical professor of obstetrics at Tufts Medical School, and a former lecturer in obstetrics at Harvard Medical School, and he was at one time an instructor in anatomy at Cornell Medical School.

Active in Medical Society Affairs

Doctor Potter has played a major role in medical society activities serving as assistant secretary of the state medical society from 1942 to 1946, as president of the Providence Medical Association in 1953, as president of the New England Obstetrical and Gynecological Society, and also as president of the nation's oldest obstetrical association, the Obstetrical Society of Boston. He has been a member of the House of Delegates of the Rhode Island Medical Society for many years, and he recently headed the committee which reported on insurance problems for health care of older-aged persons.

Doctor Adelson Re-elected Vice-President

Doctor Samuel Adelson, Newport surgeon, who has had a long and active career as a member of the Council of the Society, as well as a member of the House of Delegates, was re-elected to a second term as vice-president.

A past president of the Newport County Medical Society, Doctor Adelson has also combined an outstanding civic career with his medical practice. He has been chairman of the representative Council of the City of Newport, secretary of the Board of Health, a member of the City Charter Commission, medical examiner in Newport County, and more recently, chairman of the Newport High School Commission.

Pawtucket Leader Named President-Elect

A lifelong resident of Pawtucket, Doctor Earl J. Mara will succeed Doctor Potter as head of the medical society in 1960. He completed his elementary and high school education at Pawtucket, and he was graduated from Georgetown University with a degree of bachelor of science in 1931. Two years later he received his medical degree from the Georgetown Medical School.

Doctor Mara returned to Pawtucket for an internship at Memorial Hospital, where he is now chief of the Department of General Practice and director of the Outpatient Department. He is also a member of the staff of Notre Dame Hospital in Central Falls. A past president of the Caduceus Club, the Pawtucket Medical Association, the Memorial Hospital Staff Association, and the Memorial Hospital Interns' Association. Doctor Mara has long been active in the state medical society activities as a member of the House of Delegates, the Council and as chairman of the committee on social welfare.

New Treasurer Named by Delegates

Doctor J. Murray Beardsley, surgeon-in-chief at Rhode Island Hospital, was named by the House of Delegates to succeed the late Doctor Francis V. Garside as treasurer of the Society. Doctor Beards-

ley was treasurer of the Providence Medical Association from 1947 to 1950.

A native of Nova Scotia, he completed his elementary and collegiate studies there, receiving his degree in medicine from Dalhousie University in Halifax. After an internship at Rhode Island Hospital, and a residency at the New York Skin and Cancer Hospital, Doctor Beardsley established his private practice in Providence. He holds staff positions with most of the hospitals of the state, and he was named surgeon-in-chief at Chapin Hospital in 1946.

He has been a member of the Board of Governors of the American College of Surgeons, a member of the executive committee of the New England Surgical Society and the New England Cancer Society, a member of the Board of Directors of the Rhode Island Cancer Society, and president of the Providence Surgical Society, in addition to many other honors. Governor Del Sesto recently named him to a three-year term on the Medical Advisory Committee of the State Workmen's Compensation Commission.

Standing Committee Chairmen

Eight major committees, designated as Standing Committees whose personnel is selected by the House of Delegates, were elected and officially inducted. The following physicians were named as chairmen of these committees: Medical Economics, Doctor Stanley D. Simon of Providence; Scientific Work and Annual Meeting, Doctor Alex M. Burgess, Sr. of Providence; Public Laws, Doctor James H. Fagan of Providence; Publications, Doctor John E. Donley of Providence; Medical Defense and Grievance, Doctor Francis B. Sargent of Providence; Industrial Health, Doctor Stanley Sprague of Pawtucket; Library, Doctor Francesco Ronchese of Providence; and Public Policy and Relations, Doctor Arnold Porter of Providence.

ANNUAL MEETING OF STATE PATHOLOGISTS

The sixth annual joint meeting of the Rhode Island Society of Pathologists, Inc., with the Laboratory Club of Rhode Island, was held on May 19, 1959, at the Pawtucket Memorial Hospital. Eighty-five were in attendance, including eight members of the Society of Pathologists.

A scientific program was presented with Doctors Herbert Fanger and Joseph Song of Rhode Island Hospital reporting on the *Rhode Island Women's Cancer Cytology Survey in Cancer Detection,* Doctor David Greer of Truesdale Hospital, and Mrs. Theresa B. Escobar, discussing *Blood Ammonia Determinations:—Methodology, Interpretation of Results;* Doctor Fanger and Miss Barbara E. Barker, president of the Laboratory Club of Rhode Island, reporting on *Histochemistry of Breast Diseases;* and Mr. Thomas Connor, technologist of St. Joseph's Hospital, discussing *Clinical Application of Electrophoresis.*

RECORD LIBRARIANS ELECT

The Annual Meeting of the Rhode Island Association of Medical Record Librarians was held on Wednesday, May 13, 1959, at the Newport Hospital, Newport, Rhode Island. Miss Lois Jomini, C.R.L., presided. Mrs. Anna MacBeth, R.R.L., acted as hostess.

Robert Bestoso, M.D., president of the Staff Association of Newport Hospital, Newport, Rhode Island, was the guest speaker. His subject was *Medical Hypnosis.* He gave a brief history of hypnosis, tracing it back to the very beginning of time. Doctor Bestoso stated that hypnosis had a very definite place in medicine, especially in psychiatry, but stated that it could be rather dangerous if used without proper indications. He outlined the advantages and disadvantages of this type of treatment. He cited several cases in which this method had been very successful. A general discussion followed Doctor Bestoso's lecture.

The following officers for the year 1959-1960 were elected: *President:* Mrs. Mary N. Chase, C.R.L., Veterans Administration Hospital; *Vice-President:* Miss Mary S. Cheever, R.R.L., Kent County Memorial Hospital; *Secretary:* Miss Elizabeth Bingham, C.R.L., St. Joseph's Hospital; *Treasurer:* Miss Virginia Torres, R.R.L., Rhode Island Hospital; *Directors:* Miss Lois Jomini, C.R.L., Rhode Island Hospital, and Miss Gertrude Cahir, R.R.L., Lying-In Hospital; *Delegate to Annual Meeting:* Miss Elizabeth Bingham, C.R.L.

RIGHTS UNDER LIMITED MEDICAL LICENSE

I wish to invite your attention to the ruling of this Department concerning certain rights that are conferred upon the holders of limited medical registration certificates that have been issued under the provisions of section 5-37-16.

The holder of a limited registration to practice medicine in a hospital may sign death certificates as the need may arise in connection with his duties. This ruling is based upon an interpretation of the law by the Department of the Attorney General. The opinion stated that the act of signing a death certificate is ministerial rather than discretionary.

We have also ruled that the holders of limited medical registrations may sign papers for commitments for mental diseases.

It is understood, of course, that the right to sign such certificates is confined to the scope of practice provided by the limited registration, *i.e.,* that it applies only to the practice of medicine in the particular hospital and during the specified time covered by the limited registration certificate.

Very truly yours,
JEREMIAH A. DAILEY, M.D.
Director of Health

The RHODE ISLAND MEDICAL JOURNAL

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THE "ONE WORLD" OF TRANSMISSIBLE DISEASE

MODERN TRANSPORTATION that brings all parts of the world close together, shrinking the barriers of space and time and making us all neighbors, exposes us all to contagious diseases from the far corners of the earth as never before, despite all our efforts to prevent this. The tick that fastens on the dog in Montana may, after a rapid ride by plane, drop off in Indiana, and the rickettsia which he carries may cause the surprising occurrence of "spotted fever." The man infected with the lurking salmonella in Europe may reach his home in Massachusetts days before the incubation period of his disease has been completed. Many of the barriers which have been erected to prevent the entry of disease-bearing persons to this and other countries are inadequate to meet the challenge of modern speed.

A recent entry in the Congressional Record by Hon. Francis E. Dorn, of New York, calls attention to the marked inadequacy of federal inspection of vessels in the coastwise and foreign trade. Under the law all these vessels must be inspected, a job that requires three man-days in the case of a passenger vessel and one man-day in case of a freighter. What can a force of twenty inspectors and eighteen engineering employees of the Public Health Service do to carry out such a vast program? Such, however, is the size of the staff assigned to this work, according to the article by Mr. Dorn.

If, however, this staff were increased tenfold, or a hundredfold, we still would face the fact that modern rapid transit between countries means, of necessity, the admission of more infected individuals to our country, and from our country into other lands than ever before. It takes time to develop symptoms after the invasion of the tissues by an infectious agent—and the more rapid the transportation, the more individuals who have become infected will escape detection.

For this reason a knowledge of contagious disease as it exists in all parts of this country and of the whole world will continue to be more and more necessary to the practicing physician. While certain infections will be limited in great part to certain areas because of environmental conditions, even in such instances sporadic cases may occur anywhere —and in some of these correct diagnosis leading to proper treatment may be lifesaving. A history of travel will, of course, usually be of the greatest help, but carriers and people with sub-clinical infections can be the means of causing diseases from far away to appear in people who have never been more than a few miles away from their homes. We shall have to accept the intimate contact with all humanity that is increasingly evident, and must become familiar with all types of transmissible disease. Methods of prevention and treatment must eventually be understood and carried out everywhere as we become more and intimately associated with all the other inhabitants of our "one world."

THE LUCKLESS LEGION

ON AMERICAN ROADS the carnage by automobiles continues to grow apace and we accept it with what appears to be somnolent complacency, if not indifference. Too few of us seem to be concerned when the press informs us that 310 persons died in traffic accidents during the recent two-day Memorial weekend. This exceeds the old record of 241 for a two-day Memorial holiday set in 1953. The 310 deaths exceeded also the National Safety Council's pre-holiday estimate of 260 for the same period.

This is only part of the tragic story; for the National Safety Council reports that the toll for the first four months of this year was 10,680 deaths —a gain of 4% over the 10,270 deaths in the corresponding 1958 period. In 1958 more than 2,800,000 Americans were involved in automobile casualties.

In its annual highway safety booklet titled *The Luckless Legion,* the Travelers Insurance Company points out that this is an army which grows more rapidly each year. It includes the dead and the injured, the heedless and the innocent, the young and the old. Since the automobile first appeared upon the American scene the ranks of this legion of the dead and the crippled have included more than 60,000,000 people.

During the past year there were 36,700 men, women and children among the dead of the Luckless Legion. For every fatality there were 77 people who suffered painful injuries which, during the past year, rose 12%, twice the rate of injury for the previous year. During 1959 the Luckless Legion will be enrolling recruits on the highways, in the hospital rooms, in the morgues.

Can nothing be done to diminish this wanton carnage? Well, each of us, if he will, can help a little. When you are tempted to indulge in insensate speed, do not step on the gas; when you have the right of way, do not insist upon taking it, for many dead men had the right of way; do not try to beat the darkness home; respect the red and green lights; when vision, reflexes and alertness are dulled by fatigue or libations, remember the ancient Roman counsel to make haste slowly; beware of speeding when weather and road conditions are bad; avoid jaywalking on crowded streets as you would the pest; lastly, it is well even for physicians to remember always that the innocent internal combustion engine may be used to enhance, maim or swiftly terminate one's earthly career.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held April 15, 1959

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, April 15, 1959. The meeting was called to order by the president, Doctor Francis B. Sargent, at 8:00 P.M. The following delegates were in attendance:

BRISTOL COUNTY: Robert W. Drew, M.D. *KENT COUNTY:* Edmund T. Hackman, M.D.; Donald K. O'Hanian, M.D. *NEWPORT COUNTY:* Philomen P. Ciarla, M.D. *PAWTUCKET DISTRICT:* Earl F. Kelly, M.D.; Robert C. Hayes, M.D.; Ferdinand S. Forgiel, M.D.; Alexander Jaworski, M.D.; Harry Hecker, M.D. *WASHINGTON COUNTY:* James McGrath, M.D.; Samuel Farago, M.D. *WOONSOCKET DISTRICT:* Joseph A. Bliss, M.D.; Saul A. Wittes, M.D. *OFFICERS OF THE RIMS* (other than delegates): Francis B. Sargent, M.D. (President); Samuel Adelson, M.D. (Vice-Pres.); Alfred L. Potter, M.D. (Pres. Elect); Thomas Perry, Jr., M.D. (Secretary). *PROVIDENCE MEDICAL ASSOCIATION:* J. Robert Bowen, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William J. H. Fischer, M.D.; Henry B. Fletcher, M.D.; Frank Fratantuono, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Frank C. MacCardell, M.D.; Arnold Porter, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; William J. Schwab, M.D.; Stanley D. Simon, M.D. *ALTERNATE DELEGATE TO A.M.A.:* Arthur E. Hardy, M.D. *STATE HEALTH DEPARTMENT DIRECTOR:* Jeremiah A. Dailey, M.D.

Also present were John E. Farrell, Sc.D., executive secretary of the Society; Hannibal Hamlin, M.D., chairman, Chapin Hospital Study Committee, and Stanley Sprague, M.D., chairman, Industrial Health Committee.

The president introduced to the House of Delegates Doctor Jeremiah A. Dailey, the new State Director of Health, who by virtue of his office becomes a nonvoting member of the House of Delegates.

REPORT OF THE SECRETARY

Doctor Thomas Perry, Jr. read his report, copy of which was included in the handbook of the delegates and is made part of the official minutes of the meeting.

ACTION: It was moved that the report of the secretary be approved and placed on file. The motion was seconded and passed.

ELECTION OF OFFICERS

Doctor Earl F. Kelly, chairman of the Committee on Nominations of the Council, noted that the slate of nominees drafted by the Council had been distributed to the delegates in their handbook. He reported that in view of the death of Doctor Francis V. Garside, who had been nominated for treasurer, the Committee wished to place in nomination for the office of treasurer, Doctor J. Murray Beardsley, of Providence.

ACTION: The slate of officers as amended, as submitted by the Council of the Society, was approved and the nominees declared elected to serve the Society for the fiscal year 1959-1960.

RESOLUTION RELATIVE TO DOCTOR FRANCIS V. GARSIDE

The secretary presented the following resolution:

WHEREAS, Doctor Francis V. Garside, a member of the Rhode Island Medical Society from his first year of private practice, brought high honor and commendation to the Medical Profession of this State by his outstanding devotion and service to his patients, and

WHEREAS, he also served the Rhode Island Medical Society with distinction as its Treasurer during the past year, and as a member of the Council,

THEREFORE, Be It Resolved, That this House of Delegates of the Rhode Island Medical Society, assembled in meeting this fifteenth day of April, 1959, record its regret at the untimely death of Doctor Francis V. Garside, and that it express its sympathy to his family in their, and our, great loss.

The resolution was unanimously adopted by the House of Delegates.

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HOUSE OF DELEGATES

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DATES FOR THE 1960 ANNUAL MEETING

The secretary noted that the dates for the 1960 annual meeting had not been considered by the Council but it was important at this time that the dates be set and therefore he suggested that the house consider the dates of Tuesday, May 10 and Wednesday, May 11, 1960, for the 149th annual meeting of the Society.

ACTION: It was moved that the dates as proposed for the 1960 meeting be approved. The motion was seconded and passed.

TRUSTEE OF THE BENEVOLENCE FUND

The secretary noted that the term of Doctor Henry J. Hanley as trustee of the Benevolence Fund expires with the 1959 annual meeting of the Society.

ACTION: It was moved that Doctor Henry J. Hanley of Pawtucket be renominated for a three-year term as a trustee of the Benevolence Fund. The motion was seconded and adopted.

COMMUNICATION FROM THE STATE DIRECTOR OF LABOR

The secretary read a communication from the state director of labor in which he stated it was his intention to renominate Doctor John E. Donley as medical director of the State Curative Center for a five-year term provided such action meets with the approval of the Society.

ACTION: It was moved that the reappointment of Doctor John E. Donley as medical director of the State Curative Center be approved. The motion was seconded and unanimously adopted.

FREE CHOICE OF PHYSICIAN and CLOSED PANEL SYSTEMS

The president noted that an abstract from the report of the Commission on Medical Care Plans of the American Medical Association had been included in the delegates' handbook. Attention was directed to the request that the delegates express a decision on the following basic points:

1. *Free Choice of Physician*
   Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?
2. *Closed Panel Systems*
   What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

There was general discussion of the report and the questions posed by the American Medical Association, at the conclusion of which the following statement was adopted by the House of Delegates:

> The House of Delegates of the Rhode Island Medical Society has reviewed the report of the Commission on Medical Care Plans of the American Medical Association, as reported in the special edition of the JOURNAL OF THE A.M.A., January 17, 1959. The House has given particular attention to Section III, Free Choice of Physician, and Section IV, Third Party Relationships in Miscellaneous and Unclassified Plans.
>
> The Rhode Island Medical Society has cooperated with public and private health and welfare agencies successfully in maintaining high standards of physician care for all citizens, and the principle of free choice by the individual has been maintained with a minimum of restriction. For example, the injured employee has free choice of his physician and his hospital under the Workmen's Compensation law; the welfare recipient has free choice of his physician under a public assistance "pooled fund" or vendor program; the Physicians Service subscriber has free choice of physician whether or not the physician is a "participating physician" under agreement with the Plan; the beneficiary of the state Temporary Disability Compensation program has free choice of his physician.
>
> The House of Delegates of the Rhode Island Medical Society is of the opinion that unlimited free choice of physician is the right of any individual responsible for his own or his dependents' medical care. When a third party assumes responsibility in whole or in part for providing the individual's medical care, a modified or restricted free choice that is necessary by reason of social or economic conditions, can be acceptable and should not be a deterrent to good medical care.
>
> The House does not under any conditions approve of physician participation in any type of closed panel system that denies to the patient a normal physician-patient relationship.

RESOLUTION RELATIVE TO SOCIAL SECURITY FOR PHYSICIANS

The secretary noted that a resolution from the Kent County Medical Society had been included in the handbook to the House of Delegates. The resolution was as follows:

> That the Kent delegates request that the members of the Rhode Island Medical Society be polled on the following question—
>
> SHOULD THE UNITED STATES CONGRESS PASS LEGISLATION TO INCLUDE DOCTORS OF MEDICINE IN

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And No Dollar A Year, Either!

Behind Physicians Service is a board of directors made up of laymen and doctors. All of them are outstanding men in our State. They plan the surgical benefits to be administered to over half a million Rhode Island members.

Physicians Service is run like a business, because that's what it is. Created by legislative authority, the board of directors sits — as does any similar group in industry — to direct policies and keep things running smoothly.

There is a difference, however: these directors serve without pay. They give voluntarily of their time and fulfill their duties as conscientiously as if they were earning high salaries.

These men serve willingly without pay because Physicians Service is a community project. It is a non-profit organization. It was created to help prepay the costs of surgical, medical, or obstetrical care. It provides for medical visits in the hospital and covers surgery in your home, doctor's office or the hospital.

How well this board operates in the public interest is shown by these two facts: 1.) The Rhode Island Physicians Service Plan has the greatest percentage of persons covered of any state in the union; 2.) It operates more economically than any other plan.

From this firm basis have come extensive benefits. In addition, the directors of Physicians Service pledge to continue to offer new benefits whenever studies prove they are needed and are economically feasible.

Better Health Care for More People Through

Physicians Service

RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

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SOCIAL SECURITY COVERAGE?

and that

The delegates to the American Medical Association from the Rhode Island Medical Society be instructed to raise the question of Social Security coverage at the next A.M.A. meeting and to vote there according to the wishes of the majority in the Rhode Island state poll.

There was general discussion of the subject.

ACTION: It was moved that the members of the Rhode Island Medical Society be polled on the following question:

SHOULD THE UNITED STATES CONGRESS PASS LEGISLATION TO INCLUDE DOCTORS OF MEDICINE IN SOCIAL SECURITY COVERAGE?

The motion was seconded and adopted.

* * *

ACTION: It was moved that the poll of the membership on Social Security include the notation that the Rhode Island Delegate to the American Medical Association be instructed by the House of Delegates to vote according to the majority decision of those who answer the Society's poll. The motion was seconded and adopted.

REPORTS OF COMMITTEES

The reports of the following Committees as submitted in the handbook to the House of Delegates, and as made part of the official records of the meeting, were accepted and approved on individual motions: Benevolence Fund, Blood Bank Committee, Cancer Committee, Child-School Health Committee, Diabetes Committee, Group Liability Insurance, Highway Safety Committee, Industrial Health Committee, Library Committee, Maternal Mortality Committee, and Board of Trustees.

* * *

COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

Doctor Earl F. Kelly, chairman of the Committee on Medical Defense and Grievance, gave a brief oral report on the work of his Committee during the past year, and he also reported on a Medical-Legal Conference held in Washington and attended by the legal counsel of the Society, the president, the executive secretary, and himself.

COMMITTEE ON INSURANCE FOR THE AGED

Doctor Alfred L. Potter discussed the report of the special committee appointed by the House of Delegates to investigate the possibility of a paid up at age 65 years health insurance plan under the Rhode Island Medical Society Physicians Service. He reported that the Committee felt that in order to be useful its report must cover a larger area than was contemplated by the resolution.

The complete report was included in the handbook of the delegates and is made part of the official minutes of the meeting.

ACTION: It was moved that the House accept the report of the Committee. The motion was seconded and adopted.

* * *

The report was discussed by members of the House of Delegates and the following motion was made:

That the House of Delegates approve the report of the special committee on insurance for the aged and refer it to the standing committee on Medical Economics with the request that that Committee report back to the House of Delegates at its September meeting procedures it would recommend for implementation of the suggestions noted in the report. The motion was seconded and adopted.

* * *

A motion was made that the report of the Committee on Insurance for the Aged be given public release. The motion was seconded and adopted.

CHAPIN HOSPITAL STUDY COMMITTEE

Doctor Hannibal Hamlin noted that the report of his committee had been included in the handbook of the delegates and is thereby made part of the official minutes of the meeting. He also distributed to the members of the House a copy of the report to the Joint Committee studying the future development of the Charles V. Chapin Hospital as prepared by Doctor Theodore H. Ingalls, professor of preventive medicine and epidemiology, University of Pennsylvania School of Medicine, in 1958.

ACTION: It was moved that the House of Delegates receive and accept the report of the Chapin Hospital Study Committee and that it commend the Committee for its excellent work. The motion was seconded and adopted.

MATERNAL MORTALITY

The secretary noted that the report of the Maternal Mortality Committee was included in the handbook and was made part of the official minutes of the meeting.

ACTION: It was moved that the report of the Maternal Mortality Committee be accepted and that the president of the Society be authorized to appoint a Perinatal Mortality and Morbidity Committee, but the House does not at this time approve of any expenditure of Society funds for this Committee pending a further report from the Committee of the actual expenses it would incur. The motion was seconded and adopted.

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RESOLUTION REGARDING DOCTOR THOMAS PERRY, JR.

The following resolution was presented and unanimously adopted by the House of Delegates:

WHEREAS Doctor Thomas Perry, Jr. has served this House of Delegates and the Rhode Island Medical Society with distinction for a period of seven years, and

WHEREAS in the discharge of his duties as secretary of this Society Doctor Perry has made a notable contribution to the progressive development and success of the Society and its programs, and

WHEREAS Doctor Perry now desires to be relieved of his duties as Secretary of the Society, therefore BE IT RESOLVED that this House of Delegates, assembled in meeting on this fifteenth day of April, 1959, record its appreciation and thanks to Doctor Perry for a job exceedingly well done for the Society and the Medical Profession of Rhode Island.

* * *

Doctor Perry expressed his appreciation to the House for its expression.

REPORT OF THE HEALTH INSURANCE COMMITTEE

Doctor Robert C. Hayes, chairman of the Health Insurance Committee, discussed the Rhode Island Plan for prepaid medical-surgical insurance as sold by private insurance companies. He expressed the opinion that his Committee feels this Plan should not be continued.

There was general discussion of the subject.

ACTION: It was moved that the House of Delegates take no action on the Rhode Island Plan at this time. The motion was seconded and passed.

TENURE OF OFFICE FOR CHAIRMEN AND OFFICIAL REPRESENTATIVES

Doctor Stanley D. Simon presented a motion relative to the House taking action to establish a tenure system to prevail in the election of all standing committee chairmen and representatives of the Society.

After general discussion by members of the House, Doctor Simon withdrew the motion.

ACTION: It was moved that the House of Delegates authorize the president to appoint a committee to study and report to the House at its next meeting on suggestions for a tenure system in the election of standing committee chairmen and other official representatives of the Society. The motion was seconded and adopted.

* * *

The suggestion was made that the president also secure advice of the legal counsel of the Society relative to certain phases of the Rhode Island Plan.

ADJOURNMENT

The meeting was adjourned at 10:45 P.M.

Respectfully submitted,
THOMAS PERRY, JR., M.D., *Secretary*

REPORT OF THE SECRETARY

At a meeting held since the January meeting of the House of Delegates, the Council took the following actions:

1. It received and reviewed a statement relative to a hearing and speech center at Rhode Island Hospital.
2. It approved of the action of the Group Professional Liability Insurance Committee in establishing a new malpractice program with the St. Paul Fire and Marine Insurance Company.
3. It recommended that the questions submitted by the American Medical Association relative to free choice of physician and closed panel system based on the report of the Commission on Medical Care Plans, be submitted to the House of Delegates.
4. It authorized the president to appoint a Science Fair Awards Committee, and it voted six awards, three to senior high school students, and three to junior high school students, for the best medical or public health displays as judged by the Society's committee.
5. It voted that physicians engaged in general practice of medicine may use the listing "General Practice" after their name in telephone or other public directories in any area in which such listing does not conflict with local district medical society regulations.
6. It authorized the president to submit the names of three members of the Society from whom one would be chosen by the Director of Health to serve as a member of the Committee of Consultants to the Board of Nurse Registration and Nursing Education.
7. It received notice from the mayor of Providence that the annual C. V. Chapin Award of the City would include an honorarium of $200 to the Chapin Orator, instead of $100 as previously given.
8. It received the audit report of the Ward, Fisher and Company of the Society's finances for 1958, with the information that in their opinion the records of the Society are carefully kept and are in proper detail to reflect its operations.
9. It authorized the Board of Trustees of the Medical Library to have the exterior of the

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Library Building painted, and the granite foundation sandblasted.

10. It approved the report of the Committee on Nominations of a slate of officers and standing committees to be submitted to the House of Delegates.
11. It authorized the president and the president-elect to establish a Sesquicentennial Celebration Committee for the Society's 150th year of existence to be noted in 1962.

THOMAS PERRY, JR., M.D., *Secretary*

BENEVOLENCE FUND

During the year 1958, the Benevolence Fund received contributions in the amount of $2,892.00. We are particularly appreciative of the contribution of $300 from the Woman's Auxiliary to the Rhode Island Medical Society.

The trustees made awards to assist four physicians and their families with the total disbursements during the year amounting to $2,116.40.

At the end of 1958 the fund had a cash balance of $3,991.14, and contributions since that time have increased the fund so that the cash balance as of this date is $7,286.14.

Members of the Society are again urged to notify the trustees of any physician in serious need so that assistance may be offered if necessary.

DAVID FREEDMAN, M.D.
GEORGE W. WATERMAN, M.D.
HENRY J. HANLEY, M.D.

BLOOD BANK COMMITTEE

The present hospital system of blood banking in Rhode Island is satisfactorily meeting blood needs. There is still evident a steady trend upward in requirements for blood, in the complexity of processing techniques, in the necessity for community service and in one new area, that of providing group and type specific donors en masse for patients undergoing cardiac surgery.

In the technical area, all banks have profited from the growth of the AABB through its manuals on techniques and standards, the nation-wide reciprocity or Clearing House System, and in other phases of blood banking. All the major banks in Rhode Island are now institutional members of the AABB which means that the highly desirable and necessary features of uniformity of adequate standards of ethics, donor requirements, blood processing, handling and storage are being attained. These features assume increased importance with the growth of blood banking and provide a necessary foundation of mutual confidence to our local system of blood exchange upon need between hospitals. There has been favorable discussion on utilizing the excellent AABB Inspection and Accreditation Program for member banks in Rhode Island, in place of developing and maintaining a local program.

The increasing public demand for (1) the nation-wide transfer of blood and blood credits, and (2) Blood Assurance Programs is a healthy sign of recognition of the responsibility and importance of blood replacement.

The Rhode Island Hospital Blood Bank has, for two years, provided the opportunity for any and all residents of Rhode Island to receive and transfer blood and blood credits, from and/or to any other hospital in the country, through the AABB Clearing House System. This community service involves considerable expense which thus far the Rhode Island Hospital has been able to underwrite; how, when and where these expenses might have to be spread in the event of growth represents a potential problem.

Several banks are running Blood Assurance Programs for industrial and fraternal groups. However, it would appear that each bank will have to assume a greater share as the number of requests for these programs increases. This can be done at rather minimal expense to the hospitals, without adding employees, and without a great expense of time or effort, and represents an excellent source of blood. Actually, to a participating bank, the blood from these programs represents the only guaranteed supply in an area where day by day there is absolutely no control over either supply or demand.

Both of these public demands represent functions of community service and could perhaps be defined as outside the scope of any hospital blood bank, which technically has a primary responsibility only to the hospitalized patient. However, the Blood Bank directors within the state realize in general, that these demands must be met by our hospital Blood Bank System, since this system is preferential at the time to other systems for several reasons; it is medically supervised; it is functioning successfully, and it is under local control, although still providing opportunities for individual independence in certain areas. The preferential answer at present to the increasing requests for these programs would seem to be to absorb them into the present satisfactory hospital blood bank system through recognition, by each and every bank director, that for this system to survive, a proportionate element—with its cost—of this community service must be absorbed by each bank. Denying these public demands may well result in eventual clamor for establishment of some alternative to the hospital Blood Bank System. It would seem far more satisfactory for us to meet these demands in our own chosen manner and in good time, rather than to be forced into an alternative, perhaps medically un-

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Indications: *Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.*

Dosage: *One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.*

Precautions: *Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with* ARISTOMIN *have been relatively infrequent and minor in nature. However, since* ARISTOCORT *Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to corticosteroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.*

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References: *1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.*

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desirable system through influences outside the medical profession. It may also be wise at this time to begin consideration of courses of action to be taken if the hospital Blood Banks meet a saturation point with these programs. Within the next few years, normal and preferential growth probably would be into a medically and locally supervised community Blood Bank, which might function as an independent blood donor procurement agency for all hospitals of the state, absorb and run all the Blood Assurance Programs, and also draw the bulk of replacement donors from individual families for all hospitals.

In general, considering the rapid growth of this relatively young specialty, the present status of blood banking in Rhode Island is highly satisfactory. Continued effort will be necessary to maintain this status with tomorrow's trends.

ENOLD H. DAHLQUIST, JR., M.D., *Chairman*

CANCER COMMITTEE

The Cancer Committee of the Rhode Island Medical Society has had two training programs dealing with cancer during the past year. One was a postgraduate training seminar for general practitioners, given on two successive Sundays, October 19 and 26. The other was the annual cancer symposium presented by a group from the Roswell Park Memorial Institute on March 18.

It is planned to repeat the postgraduate seminar and possibly expand the number of subjects covered. We shall have another Cancer Seminar next year.

HERBERT FANGER, M.D., *Chairman*

CHAPIN HOSPITAL STUDY COMMITTEE

The report of the Chapin Hospital Study Committee was accepted at a previous meeting of the House of Delegates and placed on file. It is likely that none of the delegates has seen the report, and except for the newspaper coverage, would have had no opportunity to appraise the situation. Copies of the report are submitted herewith for the delegates.

The continued operation of Chapin Hospital has demonstrated its need to the whole community of Providence and the State of Rhode Island as indicated by the census statistics compiled for the past nine months. The administration and staff have voted to limit the hospital's services primarily to infectious disease and acute psychiatric illness. Both of these departments have maintained a high level of occupancy and turnover in the Richardson and East Wings, North and Hindle buildings. The cases cited in the census represent individuals who could not have been cared for at home or in other hospitals.

Acceptance of the Ingalls Report is only the first step toward implementation of its possible goals. The most important recommendation is that a closer working relationship between city and state agencies be developed in order to co-ordinate their respective health-hospital center functions effectively and economically. Chapin Hospital provides the physical space and opportunity for such co-operation. Here is the ideal location to plan a new and imperatively needed city health center subserving state administrative services as well. The advantages of contiguous housing for State Laboratories, Medical Examiner, Department of Welfare, and other agencies is clearly implied.

The House of Delegates can supply invaluable support for the attainment of aims envisaged in the Ingalls Report on Chapin Hospital toward the betterment of health facilities in Rhode Island and the Providence Plantations.

HANNIBAL HAMLIN, M.D., *Chairman*

CHILD-SCHOOL HEALTH COMMITTEE

The activities of this committee have been limited this year. Our main recommendation is that, in line with the feeling of the American Academy of Pediatrics, we urge a fourth polio "shot" be given to all those who have had their third polio "shot" over nine months before this time. We, the Committee, strongly advise follow-ups on patients who

have received one or two doses of the vaccine be done to assure that a third be given.

JOHN T. BARRETT, M.D., *Chairman*

DIABETES COMMITTEE

In view of the fact that the public has been widely informed in recent years on the importance of regular testing for diabetes, the Society's committee did not engage in the distribution of testing materials in connection with the 1958 annual campaign. The decision of the committee was also influenced by the fact that pharmaceutical companies have placed on the market at a low cost satisfactory self-testing kits for public use. Many large industrial companies have used such materials in the past year in connection with the annual diabetes detection campaign, with their industrial health personnel supervising the program.

The Society's committee did distribute several thousand leaflets and brochures, and hundreds of post cards to assist in publicizing the importance of a diabetes test. The state health department was also very active in the educational campaign.

A diabetes laymen's society is in the process of organization in the city of Providence, and this society of persons directly interested in diabetes may offer great help in the further control of the disease.

D. RICHARD BARONIAN, M.D., *Chairman*

COMMITTEE ON GROUP PROFESSIONAL LIABILITY INSURANCE

In the fall of 1958 your Committee was notified by the Lumbermen's Mutual Casualty Insurance Company that it did not plan to renew the Society's group coverage which would be subject to renewal on May 1, 1959. This action came as a surprise to the Committee in view of the fact that the group's experience had been excellent since the coverage was initiated three years ago.

After careful review of proposals, the Committee accepted one submitted by the St. Paul Fire and Marine Insurance Company, to be administered locally by Starkweather & Shepley, Inc., of Providence. All members of the group were notified of the proposed change, and new applications have been filed for most of those covered under the group.

The Committee anticipates a better supervision of the new program by the local agents, and all members of the Society are urged to join the group plan as their individual liability contracts expire during the coming months. Members should check the date of expiration of their professional liability insurance, and make an application at least one month prior to that expiration date.

HENRY C. MCDUFF, M.D., *Chairman*

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HIGHWAY SAFETY COMMITTEE

During the year the members of the Highway Safety Committee have been alerted to various safety programs through mailing of notices and brochures from the executive office. The efforts of the committee to secure passage of the so-called Alcometer Bill by the General Assembly during the 1958 session proved of no avail. The measure had strong community support, but it was not brought to the floor of the Assembly for vote.

During the year 1958, the chairman of the Committee, Doctor Arthur E. O'Dea, who has done an outstanding job in the past three years in alerting both our own membership and the general public on the need for united action against traffic fatalities and accidents, moved his residence from Rhode Island. All of us will miss Doctor O'Dea's strong and able leadership.

The committee of physicians who volunteered to assist the Department of Motor Vehicles continues to function in an advisory capacity on medical problems of applicants seeking driving permits. This group of doctors warrants praise for their willingness to take on this task in the interest of the general public. The committee will continue to give advice to the Motor Vehicle Department whenever it is asked to do so.

The legislation—Senate Bill 4 and House Bill 1018—to allow the use of chemical tests for motorists alleged to be driving under the influence of alcohol or narcotics, is again before the General Assembly. These model acts, sponsored by the State Highway Safety Council, offer a constructive step forward in the effort to protect life on our highways.

STANLEY FREEDMAN, M.D., *Chairman*

INDUSTRIAL HEALTH COMMITTEE

The Industrial Health Committee of the Rhode Island Medical Society has for years represented the Society in its efforts to improve the medical programs relating to industry and employed workers in Rhode Island. The Committee is mindful of the efforts of the Society years ago to improve the workmen's compensation law, even to the extent of introducing legislation of its own writing. The Committee is also mindful of the many news stories published locally that were critical of the efforts of the physicians to co-operate in the operation of the state workmen's compensation program.

The Industrial Health Committee, as are all citizens, is concerned with the decrease in industrial activity in the state, and it is mindful of the cost of workmen's compensation insurance benefits as a factor in this industrial recession. Within the past two years the Committee has been deeply concerned with the awards in heart cases which it believes calls for intensive study and review if *employable* cardiac patients are to be rehabilitated and continued as gainfully employed citizens.

Recently the RHODE ISLAND MEDICAL JOURNAL editorialized on some of the vexing medical problems of our workmen's compensation situation. Undoubtedly these observations were based in part on the periodic reports of this Committee to the Society which have pointed out the seriousness of the problems, and the difficulty in securing support for a strong medical viewpoint on them in the community.

The Committee, therefore, makes the following observations:

1. *Compensation for hernia.*

By legal ruling all hernias have become compensable. The Rhode Island law makes no provision for establishing criteria for compensable hernia, and we believe that such criteria should be stated in the law, or established by administrative regulation.

We maintain that in all claims for compensation for hernia resulting from personal injury received in the course of and resulting from the employee's employment, it should be definitely proved to the satisfaction of the Commission that—

a) There was an injury resulting in hernia;
b) It is reported to the employer within 48 hours after its occurrence (Sundays and holidays excluded);
c) The hernia appeared suddenly;

d) It was accompanied by pain;
e) It immediately followed an injury;
f) It did not exist prior to the injury for which compensation is claimed.

2. *Adjudication of Cardiac Cases.*

Work is important for health, and for that reason alone physicians are extremely interested in the problem of employment for the cardiac patients. We believe that heart disease and industry are not incompatible. We, therefore, are greatly concerned that heart cases become compensable by legal ruling. In our opinion exhaustive study and review of each individual case by expert impartial medical testimony must be continually sought if the interests of all workers is to be protected.

Studies and surveys have clearly indicated that work *per se* does not produce heart disease. Coronary atherosclerosis or some other form of coronary disease must have pre-existed in an individual who suffers a coronary occlusion and myocardial infarction.

It has also been demonstrated medically that performance of the same type of moderately heavy work without engaging in unusual exertion or strain has no injurious effect upon the heart. In fact, a myocardial infarction occurring during such work is not causally related to the employment, and subsequent attacks of myocardial infarction are not necessarily causally related to the first attack, but rather to the underlying pathology of the coronary vessels of the heart. In general, the emotional factor probably plays a more important role in bringing on such an attack than the physical.

We, therefore, are of the opinion that the Workmen's Compensation Commission should utilize the services of cardiologists as impartial experts in seeking advice in any case where there may be the slightest doubt in the mind of the hearing officer as to the validity of the presented medical testimony of the claimant.

We advance this proposal not in the interest of any financial saving to industry, but rather as an honest conviction voiced in the interest of the worker who is still employable, and who should be gainfully at work in spite of a cardiac condition, but who will be denied employment by industry because the compensable risk involved is too great.

3. *Back Injury Cases.*

Injuries to the back, like headaches, cannot always be clinically proved. They present a particularly vexing problem for the physician when the claim is based on employment and compensation is sought. The Rhode Island Medical Society advocated to the General Assembly in 1953 that a special report concerning industrial cases involving back injury be drafted, and in 1954 when the workmen's compensation law was revised the Society sought and obtained the inclusion of the medical provision that

> "Every physician treating any employee pursuant to this chapter shall, when the injury for which the employee is being treated involves an injury to his back which causes the loss of time for more than 7 days, file with the director of labor within 14 days after the first examination of the employee by the physician, a special report concerning such back injury. The director of labor, with the advice of the medical advisory committee, shall have the authority to prescribe the form of such special report, and may recommend specific tests to be performed in the diagnosis and treatment of such back injury with the recommendation and approval of the employee's physician."

To our best knowledge this provision has never been implemented. On the contrary, workers have been reported to have received lump sum settlements from one or more different employers for the same or a related back injury, and no special report or tests, as recommended in the statute, have been carried out.

We believe that this provision in the law should be implemented to provide the necessary legal mechanisms to allow definite action to be taken on such back reports in order to eliminate repeat lump sum compensation payments.

4. *Annual Examination of Totally Disabled Cases.*

The Committee on Industrial Health supported the inclusion in the law of the provisions that every case of total disability or severe permanent partial disability on which compensation has been paid for a period of one year shall be re-examined by the director of labor and such action taken as in the judgment of the director and the Commission, with the advice of the medical advisory committee, shall seem practicable and likely to speed the recovery and rehabilitation.

This phase of the law should be carried out as enacted by the General Assembly.

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5. *Medical Director as Member of the Commission.*

The Committee on Industrial Health maintains, as it has in behalf of the Society for years, that a full-time medical director should be included as a member of the Workmen's Compensation Commission. The program is based entirely on personal injury or illness sustained by an employee arising out of and in the course of his employment. Thus, expert medical advice is of paramount importance at all times. We believe the Commission would function more effectively in the interests of the employed worker, as well as for industry, if a doctor of medicine with experience particularly in industrial medical problems, had full-time commissioner status, sitting with the other commissioners as a body on any case, or with any one commissioner in the adjudication of a claim.

* * *

The Committee on Industrial Health of the Rhode Island Medical Society acts entirely in the interest of the employed worker, the direct beneficiary of the entire program, and its intention is not to point undue criticism to the state department of labor or the Workmen's Compensation Commission.

The Society and its committees have always been ready and available to assist any public or private agency in the operation and administration of medical phases of a program which has as its specific purpose the improvement of the health and welfare of the citizens of the state. The Department of Labor through the years has been most considerate of this attitude of the Medical Society and its Industrial Health Committee.

Some of our criticisms may run counter to legal interpretations of the present law, and we do not presume to qualify on that problem. We are directly concerned with better medical supervision of the program.

Criticism, however, objective, is never popularly received. Emotional outbursts often ensue to cloud the basic issues presented. We sincerely hope that the suggestions and recommendations advanced in this report will be accepted in the honest spirit in which they are presented.

STANLEY SPRAGUE, M.D., *Chairman*

LIBRARY COMMITTEE

The librarian and her staff have, at long last, tackled the mixed up, dusty, dilapidated, unbound journals on the third floor. It became necessary when the old accession book, dating from Doctor Hersey's time and containing the only list of most of the material stored there, disintegrated almost completely. The few journals that *were* catalogued were in such disorder that the staff needed a map

to find them. So, armed with smocks, gloves, head coverings, nose masks (and, during the winter, double sweaters and knee socks) and a Hoover Pixie vacuum, two members of the staff plunged in. They are happy to report that most of the sorting, dusting and preliminary listing has been done and the journals will be ready for re-shelving in a few weeks. The next project will be the second floor, where the textbooks, though catalogued, are in great disorder. If all goes well, the stacks will be in order by the end of October, in time for the meeting of the New England Regional Medical Librarians which is being held in our building, and we'll be proud instead of ashamed to show visitors our collection.

We were happy to be in the position of helping two libraries increase their holdings by sending them material from our large collection of duplicates. One hundred sixty-nine journals were sent to the Westchester Academy Medical Library and 104 bound volumes and 884 single issues were sent to the University of Kentucky Medical Center Library. We offered 173 journals through the Medical Library Association Exchange. There will be room in the storeroom now for the duplicates we're finding on the third floor. All shipping charges are, of course, paid by the library requesting the duplicate material.

The librarian attended the first meeting of the New England Regional Medical Librarians, held in Boston on December 5, 6, 1958. The sessions were held at the Boston Medical Library and the Harvard Medical School and the discussions included the subjects of Interlibrary Loan and Serials Work. It was an interesting and informative meeting.

Doctor Stanley S. Freedman has contributed to the appearance of the Reading Room by having the library clock cleaned, overhauled, polished and regilded. And our many other friends of the library have been generous with gifts of books and journals. These gifts are noted in *On the Medical Library Bookshelves* throughout the year but we wish to thank them again for their contributions.

Statistics for April 9, 1958, to April 1, 1959: We have added 181 bound volumes (209 were received but the duplicates were discarded) to our collection, making a total of 42,433. Our readers numbered 1,941, of whom 1,166 were physicians and 775 general public. Circulation included 1,591 periodicals and 426 books; of these 80 were borrowed from the Davenport Collection. We are happy to see that circulation of the books in this collection is increasing and wish to call the attention of the Fellows to the fact that they may borrow these nonmedical texts by medical men and that we add new titles each year. We borrowed eleven items through our interlibrary loan and loaned 586 to other libraries in Rhode Island and Massachusetts.

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The last figure indicates our importance as a repository library where smaller libraries may call for material not on their shelves. Two hundred and nineteen bibliographies were prepared. We are receiving 406 periodicals currently; 97 volumes of journals have been bound and 39 are being processed at the present time. Through the Medical Library Association Exchange, we have been fortunate in acquiring 19 single journals (completing 4 volumes) and 2 bound volumes of the early ARCHIVES OF NEUROLOGY AND PSYCHIATRY which we lacked. Cataloguing is proceeding slowly with 31,486 bound volumes and 3,919 unbound volumes and pamphlets completed.

The Committee wishes to express its sincere appreciation of the devoted service which has been rendered during the past year, as in previous years, by the staff, consisting of Mrs. Helen DeJong, librarian; Miss Grace Dickerman, librarian emerita, and Mrs. Joann Watson, assistant librarian.

IRVING A. BECK, M.D., *Chairman*

MATERNAL MORTALITY

Subject: Report on the proposed formation of a Perinatal Mortality and Morbidity Committee for the Rhode Island State Medical Society.

From: the Sub-Committee of the Maternal Mortality Committee of the Rhode Island Medical Society.

To: the Chairman of the Maternal Mortality Committee, Rhode Island Medical Society.

Date of Meeting: February 17, 1959

Committee Members: *Chairman*, Dr. Bertram H. Buxton, Jr.; Doctors William J. MacDonald; William A. Reid, and George Anderson.

Invited Participants: Dr. Eric Denhoff and Dr. Herbert Ebner.

The Subcommittee unanimously agreed that there existed an urgent need for the formation of a Perinatal Mortality and Morbidity Committee of the Rhode Island Medical Society. Beyond the fundamental and idealistic objective of contributing to the ultimate goal of a normally developed and emotionally well-adjusted child for each conception are more immediate reasons. These include a means of educating patients, physicians and nurses, the improvement of physical, emotional and social environments of pregnancy and the improvement of the physical facilities in which the infant is born and subsequently cared for. Finally, it is obvious that such a committee, through its investigations and studies might identify needs for further investigation and research, particularly in this state, where geographical compactness lends itself well to case findings and complete follow-ups.

The objective of such a committee, generally, would be that proposed in the supplementary report of the council on Medical Education of the American Medical Association, titled, *A Guide for the Study of Perinatal Mortality and Morbidity*. This general objective of a Perinatal Mortality and Morbidity Committee should be to improve the production of normal human beings by eliminating deaths and damage during the reproductive process. In achieving this goal, all individuals and committees should rigidly and courteously adhere to scientific and ethical principals.

A specific objective of this committee should include, at the outset, the adoption of uniform terms and definitions and rates for all perinatal deaths occurring within the State of Rhode Island, in conformance with the recommendations of the American Medical Association Committee of Maternal and Child Care. This will facilitate national and international comparison.

A main objective and function of the State Perinatal Mortality and Morbidity Committee should be to entice, urge, support and help develop the formation of hospital perinatal mortality and morbidity committees throughout the state in hospitals where obstetrics is practiced. The Committee agrees that this can be done only through vigorous and enthusiastic campaigning and education, and recognizes that through its State Medical Journal, this Committee may secure and obtain the co-operative action on the part of all hospitals and obstetric and newborn units in the state.

A further objective of this Committee would be to form a strong liaison with the Rhode Island Department of Health, not only in standardizing terms and definitions, but eliciting their support and close co-operation in obtaining accurate data from the various hospitals throughout the state. Without such strong co-operation between this Committee and the State Department of Health, the program would be ineffective.

The function of this Committee would be one primarily of co-ordination and processing of data, the institution of uniform reporting of all perinatal mortalities and the preparation of reports and special articles for publication in the state medical journal. It is probable in the initial year of this Committee's formation that specific case findings and processing of total data would not be feasible, since groundwork on the development of Hospital Perinatal Mortality and Morbidity Committees would only have just begun. However, basic tables of perinatal mortality split into neonatal and fetal deaths in 500 gram increments would be a decided improvement over the past lack of uniformity in reporting such data and it feels the Committee can entertain and undertake a special report in its first year of origin on some such subject as perinatal mortality in Caesarean section, for example.

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This Subcommittee feels that the personnel of such a Committee should include obstetricians and pediatricians from the various hospitals in the state wherein obstetrics is done. It recommends the naming of an anesthetist who is familiar where obstetric anesthesia and resuscitation of the newborn, as well as a pathologist who has interest, as well as the background and experience in neonatal physiopathology. The personnel of this Committee should also include the director of Health of the State of Rhode Island or his designate, as well as the director in the State of Maternal and Child Health. A member of the State Department of Health Statistical Department should be included and as the Committee's concern in this important field grows the recommendations of the A.M.A.'s report on Perinatal Mortality and Morbidity Committee should be observed by the inclusion of members of the nursing profession and personnel from the social welfare agencies in the state.

The costs arising from the expense of such a Committee for staff personnel, bookkeeping, supplies and travel should be met from the treasury of the Rhode Island Medical Society and/or from the State Health Department.

The Subcommittee further recommends that a specific meeting place, such as the Rhode Island Medical Library, be chosen and that meetings be scheduled at least monthly. The Subcommittee feels that it should leave to the Committee, once established, the design and inception of a uniform data sheet for the recording of pertinent items in connection with any case of perinatal mortality.

In summary then, this Committee recommends to the chairman of the Maternal Mortality Committee that he recommend in turn to the president of the Medical Society that a Perinatal Mortality and Morbidity Committee of the State Medical Society be formed and submit to said president sufficient specific recommendations to enable the president of the Medical Society to name a Perinatal Mortality and Morbidity Committee, which will possess the necessary qualifications, enthusiasm and perspective to make this committee as effective as possible, as early as possible.

BERTRAM BUXTON, JR., M.D., *Chairman*

BOARD OF TRUSTEES OF THE MEDICAL LIBRARY

The extensive repairs and additions provided in 1957 and 1958 have put the Medical Library building in excellent condition, and have also provided better facilities for the members, the public, and for the employees of both the Society and the Medical Bureau of the Providence Medical Association.

The trustees have noted for some time the discoloration of the granite foundations as the result of rust drippings from the iron balconies on the second floor. The Council recently authorized the trustees to have the foundation and the granite entrance steps, the platforms and limestone columns, sandblasted. We feel certain this will restore to the lower exterior of the building its former beauty. If this work proves as satisfactory as we hope, then the cornice sills, lintels and capstones may be cleaned later in the year by the same method.

In addition, the trustees have been authorized to contract for the painting of the exterior of the Library, and this work should be completed in the month of April.

As has been noted before, the Medical Library building is an asset that probably is not fully appreciated by all our Society membership. Exclusive of contents, or the land on which it is located, the Library building replacement value is over a quarter of a million dollars.

Visitors from other states have been high in their praise of our Library and its facilities, and we are indeed indebted to the members of the Rhode Island Medical Society who contributed to make the building possible in 1912. We all have an obligation to keep the building in excellent physical condition, and we all have reason to be proud of the fact that our own membership maintains one of the finest medical libraries in the nation.

SAMUEL ADELSON, M.D., *Chairman*

REPORT OF THE COMMITTEE ON INSURANCE FOR OLDER AGE PERSONS

Submitted to the House of Delegates, April 15, 1959

THE House of Delegates in September, 1958, established a special committee "to investigate the possibility of a paid-up at age 65 years health insurance plan under the Rhode Island Medical Society Physicians' Service Plan from the following points of view:

1. Its effectiveness as a specific measure to combat governmental health plans for the aged,
2. Its financial feasibility, and
3. Its public acceptance.

The committee would report to the House of Delegates within six months.

The committee feels that in order to be useful, its report must cover a larger area than was contemplated by the resolution.

Your committee feels that the average American citizen prefers the voluntary way of meeting his personal problems as opposed to subjection to governmental supervision. We believe that a voluntary medical care plan will be welcomed by the public rather than a government controlled and tax supported program. We believe that the problem has been exaggerated by those using it for political reasons and that the existing means for its relief are minimized. That there is a problem, and always will be, is obvious, but we believe that it can be better taken care of by existing agencies than by turning to the Federal government in Washington.

To get a proper perspective on the problem of health care of the elderly, or the citizen over 65 as some prefer the classification, here are some considerations:

1. People now live longer. There are more people over 65 than ever before, and their numbers are increasing. There were 15,000,000 in the United States last year, 1 in 10 of our population. It is quite certain that by 1980 there will be 1 in 11, or 25,000,000 over 65.

2. With increasing age there is increased use of doctors' and hospital services, more for this group than any except infants. Hospital use by the aged is 21%, as contrasted with 11% for all ages. In addition to increased incidence of use, the elderly have a longer stay in hospital, and a higher usage of specialists.

3. After 65 unemployment drops off sharply, and with retirement comes diminished income. As many of these persons have had some form of insurance paid for wholly or in part by their employers, as fringe benefits and not part of their "take-home pay," they are not used to paying for insurance out of their pocket. They are not insurance-minded, and in many cases drop their coverage even when the insurer might be willing to continue the policy.

4. Even when the policy may be continued, many face increased rates or diminishing benefits, making its continuance unattractive.

Hence at an age when their need for health care is increasing, the ability of many of the over 65 to carry insurance, or even its availability, becomes reduced.

The Committee on Aging of the American Medical Association which has been thoroughly going into this and allied problems urged last fall:

1. Promote among the general population a realistic attitude toward aging and the importance of preparation for senior citizenship. (Here your committee would put that into plain English: We are all getting older. Every man will die some day, sooner or later. Every man will have a terminal illness of long or short duration, and before that time he will begin to wear out.)

2. Develop effective methods of financing health care for the aged primarily through voluntary health insurance prepayment plans, and secondly, for the indigent, through community or state aid.

3. Provide increased facilities for the aged through the Hill-Burton Act by building nursing homes and chronic disease units.

4. Health maintenance programs, morale builders, etc.

In discussing "health care" it is only fair to both the doctors and the hospitals to consider "doctors' bills" and hospital bills separately. For years the patient has used the term "doctors' bills" to express the total cost of his illness or operation. When hospitals were a last resort, a place to go to die, and when the cost of hospitalization was relatively low, the total cost was not too far out of line. The American consumer, according to the Department of Commerce, now spends proportionately more of his dollar for various medical services, health insurance, hospitals, ophthalmic care, orthopedic appli-

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INSURANCE FOR OLDER AGE PERSONS

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ances, and doctors than he did ten or twenty years ago. The quality of these services has improved and the quantity is available for his larger outlay. Medical care is now a part of his family budget.

In 1929, thirty years ago, the Commerce Department gave three billion dollars as the aggregate cost of medical care. By 1957 this total was fifteen billion. This five times increase was in part due to population increase, but on a per capita basis rose from $24 to $89. By relation to consumer price index this was 32 in 1929 and 65 in 1957, about double. However, the disposable personal income per capita (after taxes) rose from $683 in 1929 to $1,812 in 1957, triple in amount.

The physicians' share of the dollar spent for medical care has dropped from 33 cents in 1929 to 24.5 cents in 1957.

The cost of hospitalization has necessarily soared and is now increasing at better than 5% a year. Actual "doctors' bills" for years have been at a relative standstill.

The American consumer has become habituated to spending more of his increased income for medical care as part of his increased standard of living and is aware of the value of good medical care. He is willing to pay for it when he can. He now pays 1.3% of his income for doctors as opposed to 3.2 for alcoholic beverages, as compared with 1.2% and 5.2% in 1947, and almost as much for total medical care (5.3%) as for recreation (5.6%).

For our discussion only one of the three groups into which we may divide the elderly concerns this report.

1. There are those who have been able to save for their old age or have financial means so that their health care is no great problem.

2. There are the indigent, whom we have always had with us; the unfortunate who, not through their own improvidence, have been overwhelmed by catastrophic illness; and the thriftless, and society's misfits whom we must care for.

It seems to your committee that these latter groups can be best cared for by their own community or state. (Our hospitals cannot long go on caring for this group below cost, either through the increased cost to other patients by increased rates, or by continued deficits of the hospitals.) We might suggest here that this group need not be segregated as far as health care if the local government were to insure these indigents, making available the care their fellows enjoy. Such plans would require no duplication by a new bureaucracy to collect taxes and redistribute them throughout our country, but leaves our present well-functioning plans to continue to explore and develop as they are doing. Our Blue Cross-Physicians Service, nonprofit making community organizations, seems ideal for this function.

3. There is left for our discussion the elderly who are turned out to pasture after a lifetime of work during which they have been protected by sick benefits from employer and probably by fringe benefits in some form of health insurance, private or Blue Cross-Physicians Service. With retirement their fringe benefits stop, their income drops, and they are an undesirable group from the "experience rating" insurance standpoint. A survey in 1957 showed that 3 of 8 over 65 had some form of voluntary health insurance, 1 of 6 had carried it up to five years ago, 2 of 3 said they would like insurance to cover all expenses, and 3 of 5 were either not insured, had it formerly, had been rejected, or never tried to get it.

Our Rhode Island Blue Cross-Physicians Service covers the over 65 age group under the same rates as before reaching this age, using the community rating policy, but it can be seen that this puts these Plans at a disadvantage in competition for group contracts with a private insurance company whose cost to an employer is based on an experience rating of a group of young and middle-aged men. Also at the time of retirement the insured is no longer to be carried on a group contract; he is up rated, given lesser benefits, or even urged then to transfer to the Blue Cross-Physicians Service. The administrative cost of the individual as compared with the group policy is about double.

Physicians Service and Blue Cross are nonprofit organizations, but to give the benefits to their policyholders as contracted, they must by law keep solvent, maintain the required reserves, and conform to the requirements properly insisted upon by the Commissioner of Insurance. Up to this point the Plans are public benefactors. Some insurance commissioners frown upon one insured group of the population being subsidized by the other carriers. Throughout the nation the Blue Cross and Blue Shield Plans have not been as considerate of the elderly as have been our Rhode Island Plans. Many states urged by the American Medical Association in the past few months are changing this attitude, and there are also now more policies being offered by private companies designed for the elderly, but none can be compared favorably with our Rhode Island Plans. This is not new. In rates and in economy of operation the Rhode Island Plans have always been outstanding.

The executive director of the Blue Cross-Physicians Service reported recently that "of the more than 70,000 people in the state who are over the age 65, approximately 56,500 are enrolled in Blue Cross and 41,000 are enrolled in Physicians Service" and right now "we have over 400 people between the ages of 90 and 99 enrolled in Blue Cross and over

300 in Physicians Service. In addition, there are more than 5,000 between the ages of 80 and 89 in Blue Cross and nearly 4,000 in Physicians Service." Our plans, then, allow subscribers to continue as members regardless of age, and with no reduced benefits.

All prepaid health insurance is relatively new, and insurance for the aged has little experience on which to base its rates. There must be trial and experiment. All over our country there are groups studying the problem, trying various plans which best suit local conditions. There are plans for complete coverage, such as the Windsor, Ontario, plan, which is apparently satisfactory there; there are plans to include care in the home; plans with or without deductible features. Until the evidence is in we must await the verdict.

As doctors we cannot directly control hospital costs, which are by far the heaviest expense. We can keep down unnecessary admissions; we could do more by having many diagnostic procedures done before admission. Such a plan requires changes in Blue Cross regulations covering laboratory and other costs of diagnosis done outside the hospital.

The one thing we can do as a group of doctors is to continue to do what we as a profession have done always, care for the needy and those whose income level deserves our consideration by accepting payment for services according to the income level. This is Physicians Service (the doctors' own plan) and your committee feels that a doctor who does not join and bear his share of this obligation is not doing his duty. Under it there has never been an increase in rates or decrease in services and benefits directed at those over 65, and as their income drops their cost for a surgical operation is completely covered.

The question of prepaid insurance other than on an annual basis seems unanswerable. During his productive years a man may and can, by one of the many forms of insurance available, set up a fund to draw upon at sixty-five or any age desired for future illness care. But no actuary can reasonably foretell from past costs, or prophesy of the future value of the dollar, what future medical costs will be. Hospital costs now rise better than 5% a year. Only an indemnity form of insurance paying so much a year toward some future illness in 1965 or 1980 could be written. Suggestion is made that the worker might set aside a yearly sum tax-free during his productive years to enable him to care for his health in his old age. This would seem to your committee too sensible, smacking too much of old-fashioned thrift, to find acceptance by those who want these things done by a beneficent government. An employer can hardly be expected to do this. The younger employees may properly object to contribute for their elders by a decrease in their take-home pay, unless human nature changes. Even the Federal government with its vast social security system providing old age and survivors "insurance," so-called, does not attempt to guarantee anything but a cash indemnity. The Social Security System promises a cash indemnity at the age of 65, but it gives no assurance that this indemnity to be paid at some future date will have the same purchasing power that it has today; and further, it retains the right to alter at any time the premium charge (taxes) to be imposed on the compulsory "contributor." Hence a prepaid insurance to cover the health needs in the future, without changing the rules as time goes by is impossible.

We believe that the physicians of Rhode Island, through their voluntary Physicians Service Program, will continue to seek ways to aid all persons, and particularly the older aged group for whom there is so much concern lately. We offer the following suggestions as possible avenues to be followed in the expansion of benefits for the over 65 age persons:

1. The physicians of Rhode Island have always been willing, of their own initiative, to accept a reduced fee, or no fee, for home or office visits for older aged persons with limited financial resources. As was attested in a recent appraisal of the financial operations of the state government, physicians in the state gave over a half million dollars of free service in the fiscal year 1956-57 to public assistance recipients, many of whom were undoubtedly over 65. We suggest, however, that the House of Delegates of the Society consider the advisability of exploring a possible reduced fee schedule for home and office visits for persons over 65 whose annual income is the same as Physicians Service income limits.

2. We suggest that the House of Delegates urge that management and labor explore the possibility and feasibility of the continuance of Blue Cross and Physicians Service coverage for all employees upon their retirement after a stipulated term of service with a given employer, the premium to be paid by the employer, or jointly by the employer and employee for comprehensive plan coverage.

3. We suggest that the Blue Cross explore with hospital administrators and boards of hospital trustees the possibility of an insurance that would provide hospital expenses for the elderly at a special premium rate, such as is currently being developed in Iowa.

4. We suggest that the House of Delegates urge upon the insurance industry, through its national associations, the elimination of health and accident insurance cancellations because of age.

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5. We urge co-operation by the public, by our political representatives, and by our newspapers in solving this problem wisely, and not impulsively by hasty action.

Once we turn down a wrong road the return may be difficult or impossible. We doctors hear no loud clamor for the grocers to cut their prices for the elderly, or for landlords to lower their rents for those over 65, but, although the public has been told on the highest authority that every citizen is entitled to be well-clothed, well-housed, and well-fed, only the doctors have and will continue to adjust their charges below their fair and usual fee for service through their Physicians Service plan and as far as possible through the Blue Cross to which it is allied.

6. In conclusion we would point out that while medicine will do its part to bring about continued improvements in voluntary health insurance programs, we must have equally strong support from employers, labor organizations, insurance companies, and the people themselves. We believe that society has the responsibility to provide necessities, of which medical care is only one, to those persons who are unable to provide for themselves.

We are convinced that the people requiring such assistance are a small portion of the total in any age group, and our common efforts must be directed toward developing programs for keeping elderly people well and productive through proper health maintenance and proper living. A healthy, elderly person, with the assistance of voluntary prepayment health plans, will not only be in a position to purchase a major portion of his medical care needs, but, in our opinion, he will want to do so because of the maturity and wisdom through living experience that has given him his increased years of life.

Committee to Study Paid-up Health Insurance at Age 65
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